



RELEASE OF HEALTHCARE INFORMATION

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ MR#: \_\_\_\_\_

This will authorize (MEDICAL PROVIDERS NAME) \_\_\_\_\_ and its related entities to use and/or disclose my protected health information for the following purpose.

Name of person or entity receiving information: \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

Purpose:  Insurance  Legal Matter  Personal  School

Information to Be Disclosed.

Note: Information to be disclosed may include, as applicable, information related to mental health, drug or alcohol treatment, genetic testing, HIV/AIDS, and psychotherapy notes.

I authorize disclosure of the following information:

Complete Medical Record

OR

Records from the following dates: \_\_\_\_\_ to \_\_\_\_\_ .

OR

I only want the following parts of my medical record to be disclosed, I will list them here:

\_\_\_\_\_  
\_\_\_\_\_

If the choice I made above contains certain information I do not want disclosed, I will list it below:

\_\_\_\_\_  
\_\_\_\_\_

Method of Delivery:  Mail to receiving entity above  FAX # \_\_\_\_\_

- You may revoke this Authorization at any time, in writing, except to the extent that we have already relied upon it in making a disclosure. Your written revocation will become effective when we receive it. If you are providing this Authorization to obtain insurance coverage, you may not have the right to revoke the Authorization in the future to the extent that it pertains to the insurer's right under law to contest a claim under your insurance policy. If you wish to revoke this Authorization, please send your written request to: Gragil Associates, Inc., P.O. Box 1010, Pembroke, MA 02359.
- I understand that if I authorize disclosure of protected health information, the recipient may further disclose this information, and Federal law may no longer protect it.

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Signature of Patient or Legal Representative / Guardian Date

(Legal Handwritten Signature Accepted Only)

Form can be emailed, mailed or FAXED to:

Gragil Associates, Inc.  
P.O. Box 1010  
Pembroke, MA 02359  
FAX: 781-826-6367  
collections@gragil.com