



Riverside Medical Group  
 275 Varnum Ave Suite 201  
 Lowell, MA 01854  
 Phone 978-452-9700 Fax 978-441-6075

**Authorization for Release of Medical Information**

Please complete the form thoroughly. Your medical records cannot be released until this form is completed, signed by the patient or legal guardian, and returned to this office.

**Patient Information**

Patient Full Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Any other Previous Names: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I hereby authorize Riverside Medical Group to (please pick one)**

Release my medical information to  Obtain records from

Name/Facility: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax: \_\_\_\_\_

**Purpose of request**

Medical Treatment  Transfer to new Doctor  Personal

**Information to be released**

Please provide a 2-year abstract of my records including any Colonoscopy/Mammogram/Immz  
 Other-please be specific, include dates and MD's \_\_\_\_\_

**Authorization to Release Protected Information**

Yes  No  Mental Health Information      Yes  No  HIV Tests & Related Information  
 Yes  No  Alcohol and/or Substance Abuse Treatment      Yes  No  Genetic Testing  
 Yes  No  Social Worker Communication      Yes  No  Sexual/Physical Abuse  
 Yes  No  Sexually Transmitted Disease (STD's)      Yes  No  Other \_\_\_\_\_

I have carefully read and understand the above statement, and so herein expressly and voluntarily consent to the disclosure of the above information about, or medical records of my condition to those persons or agencies named above. I hereby release the above-named physician and covering physicians from all liability that may arise from the release of my medical records. This authorization will expire 12 months from the date shown below unless you specify otherwise (enter date \_\_\_\_\_). Records released are not for re-disclosure without patient informed consent.

\_\_\_\_\_  
 Patient/Legal Guardian Signature      Date