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

☐ Permission to speak to _____

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