DOWD MEDICAL ASSOCIATES
107 Woburn St, Reading, MA 01867
Phone: 781 944-4250 Fax: 781 944-2276

Howard W. Rashba MD
Mark J. Curdo MD
Robin A. Smith MD
Jennifer M. Corwin MD
Joan W. Sachs MD
Sarah P. Crowley MD
Lucy P. Delaney CPNP

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(*MUST* COMPLETE *ALL* SECTIONS 1-5)

1.

Patient's Name: ____________________________ Date of Birth ________________________________

Contact Phone #: ___________________________

I authorize Dowd Medical to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ______________________________ State: __________ Zip Code: ________________

2.

Purpose of Release: ☐Medical Care Coordination ☐ Legal Matter ☐ Insurance ☐ Personal
☐*Transferring Care ☐ Other

*If Transferring Care Reason: Check all that apply
☐ Insurance change ☐ Moving/Planning to move ☐ Location/ closer MD
☐Transfer to Adult Care
☐Other

3.

This request and authorization applies to:

☐Healthcare information relating to the following treatment, condition, or dates:

____

☐Abstract (Includes Immunizations, 2 yrs of Office Visits, Specialists Notes and Labs, 5 yrs of Radiology reports)

4.

*****Please review below: Section A. or B. MUST be completed or form will be returned and may delay record release.**

A. Release of information requiring specific consent (The following categories of information may be included in your medical record and WILL NOT be released unless you indicate your specific authorization by INITIALING each appropriate category.

_____Behavioral/Mental Health (including ADD/ADHD) _____ Alcohol/Drug Abuse
_____HIV,AIDS, STD Results/Treatment _____ Domestic Violence
_____Rape/Sexual Assault/Pregnancy/Abortion _____ Genetic Testing

B. I do not either want or have any of the above information to be released. _______

5.

Patient Signature: ____ Date Signed: _________________
(Guardian if under 18 years of age)

For office use:
☐ Chart copied ☐ Given to Nurse/MA________ ☐ Given to PCP ________ ☐ PCP signed ___________
☐ Called patient ☐ Mailed (Date ____________) ☐ Picked up (Date ____________) ☐ Scanned