Fitzpatrick, Moran, Costa, Haag-Rickert, M.D

Obstetrics & Gynecology
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records (check one) _____ TO _____ FROM

Fitzpatrick, Moran, Costa, Haag-Rickert, M.D.
299 Carew Street, Suite 215
Springfield, MA 01104

_____ TO _____ FROM Name and address of health care provider:

_____

_____

_____

Place a check mark below to indicate the records you wish to release:

_____ All Records _____ Lab Reports _____ Pap

_____ Ultrasounds _____ Doctors' Notes _____ Other

_____

Reason for release of records: _____

_____

I understand that my express consent is required to release any health information relating to testing, diagnosis, and treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnosis, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by Federal Regulations (42 C.F.R. Part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked at any time and that, upon fulfillment of the above purpose this consent will expire one year following the date of signature.

Permission to fax records? _____ Yes _____ No

Patient Name: _____ DOB: _____

Signature: _____ Date: _____
Patient or Legal Guardian