MEDICAL RECORDS RELEASE FORM

Ram Clinic P.C.

1206 Boston Providence Hwy. Suite 210 Norwood, MA 02062
Ph: 781-333-3444 Fax: 781-680-7121

Release Medical Records From:

☐ Release from Ram Clinic P.C. at address above
☐ Release from entity as addressed below

_____
Doctor/Hospital

_____
Street Address

_____
City, State, Zip code

(_____)_____-_____
Phone Number
(_____)_____-_____
Fax Number

Release Medical Records To:

☐ Send to Ram Clinic P.C. at address above
☐ Send to entity as addressed below

_____
Doctor/Hospital/Individual/Organization

_____
Street Address

_____
City, State, Zip code

(_____)_____-_____
Phone Number
(_____)_____-_____
Fax Number

Patient Information:

_____
Print Patient's Full Name

_____
Date of Birth (MM/DD/YYYY)

_____
Street Address

_____
City, State, Zip Code

(_____)_____-_____
Phone Number

(_____)_____-_____
Alternate Phone Number

Release the following records (initial next to one or more selections):

_____ 2 years of medical records

_____ Specific records (please indicate specific records to be sent)_____

_____ Other (please indicate)_____

*** Please complete and sign second page**

Purpose of Discloser(check one or more selections):

____Referral to Specialist ____Changing Providers ____Personal Use* ___Insurance ___Other
(If other is selected, please indicate purpose)_____
*Please note that there will be a charge for records disclosed to patient for personal use.

Please initial next to each statement to confirm that you have read, understand, and agree with the following:

___ I understand that information in my health record may include information relating to sexually transmitted disease, AIDS, HIV, and other communicable disease, behavior health, consult/treatment of alcohol and/or drug abuse. My signature releases such information.

___I may refuse to sign this authorization form, and records will not be released.

___I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.

___I understand that if this information is disclosed to a third party, the information may no longer be protected by state and/or federal regulations and may be re-disclosed by the person or entity that receives the information.

___I release Ram Clinic P.C and its employees from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____

Signature of Patient or Legally Authorized Individual **Todays Date**

_____ _____

Printed name of person signing release **Relationship to signer if other than patient**