5 Shrewsbury St, Ste D, Holden MA 01520
Phone 508-829-3800 – Fax 508-829-3802

MEDICAL RECORDS REQUEST FORM

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ DOB: _____ / _____ / _______

I hereby give authorization for the use or disclosure of the above individual's health information as described:

1. ☐ Released **From**: Urgent Care of Holden
   To (complete below) via protected fax:

   ☐ Released **To**: Urgent Care of Holden
   From (complete below) via protected fax:

Facility / Provider ______________________________

Street Address ______________________________

City / Town ______________________ State _________ Zip __________

Phone # (_______) _______ — __________ **Fax # (_______) _______ — __________**

2. Type of information to be used or disclosed (check all that may apply):

- ☐ All Medical Records types on file
- ☐ Visit Encounter Providers Chart Only
- ☐ Other: ______________________________
- ☐ Radiology Reports
- ☐ Laboratory Test Results

3. **Including any of the following related confidential information protected under state law** (check all that may apply):

- ☐ Reportable Sexually Transmitted Diseases
- ☐ HIV / AIDS results

4. **Dates of service requested** (check one):

- ☐ All Service Dates on File
- ☐ Specific date(s): ______________________________

5. **The information I am authorizing disclosure for will be used for the following purpose** (check all that may apply):

- ☐ Appointment with Specialist
- ☐ Continued / Coordination of Care
- ☐ Other: (Please describe) ______________________________
- ☐ Attorney / Legal Purposes
- ☐ My Personal Use

I understand that:

- This authorization is voluntary. Any disclosure carries the potential for unauthorized re-disclosure. I release Urgent Care Specialists, PC d/b/a Urgent Care of Holden from any legal liability that may arise from the disclosures or re-disclosure of this information.
- Unless otherwise revoked, this authorization will be valid for only ninety (90) days from the date of signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.
- I have read and understand the above statements and authorize the disclosure of the information requested:

______________________________ ____________ ______________________________

Signature of Patient / Parent / Legal Representative | Date | *Signer's Relationship to Patient*