RIVER VALLEY INFECTIOUS DISEASE SPECIALISTS INC.
AND RIVER VALLEY TRAVEL MEDICINE LLC
Authorization to Release Medical Records

Patient Information ** Please Print **

Patient Full Name: _____ Date of Birth: _____

Patient Address _____ Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Release/Send Information To

I hereby authorize River Valley Infectious Disease Specialists Inc. and River Valley Travel Medicine LLC to release information contained in my medical record via fax and/or mail to:

Name/Facility: **JOSEPH GROSS, MD, BEVERLY HOSPITAL, LAHEY MEDICAL** Attention:_____

Address: _____ Phone:_____

City: _____ State: _____ Zip: _____ Fax #:_____

Information to Release/Send

☐ Please provide History/physical, Summary, Consult, Intake, Labs, Radiology, EKGs, ER report for 2 years prior

☐ Please provide a copy of all lab work

☐ Other – please be specific, including dates, MDs, tests (fill in box)→

Comments / Dates / Notes

Purpose of Request:

☐ Personal ☐ Continuing Care ☐ Insurance ☐ Legal

☐ Other: _____

Authorization to Release/Send Protected or Sensitive Information.

In order for us to release any of your medical information that may fall into the categories listed below, you must initial on the line. We will not send out this information if the line is blank → **WRITE YOUR INITIALS ON THE LINE**

I authorize psychiatric/psychological treatment notes to be released _____

I authorize information about drug &/or alcohol substance abuse/treatment to be released _____

I authorize information about sexually transmitted disease to be released _____

I authorize information about HIV/AIDS testing &/or treatment to be released _____

Please make sure you have filled out this form completely: printing your full name and date of birth, checking the purpose of the request, checking the information to be released, and initialing ALL the protected/sensitive information categories above that may pertain to your records.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer or Director of Health Information.

I understand that I have a right to revoke this authorization; I must do so in writing and present my written revocation to the Medical Records/Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 6 months from the date of signing.

_____ _____ _____

Signature - Attach legal documents when applicable **Date / Time**