REQUEST FOR RELEASE OF MEDICAL RECORDS

Groton Medical Associates
100 Boston Road, Suite E
Groton, MA 01450
T: (978)448-4300 F: (978)448-4040

Records are to be received and/or transferred by paper copies only

Fees:
$30.00 to transfer records directly to another practice (Records for the past 3 years)
$75.00 to release records directly to the patient (This can increase based upon how many years you are requesting)

Patient Name | Date of Birth | Phone

Address | City/State/Zip Code

I hereby authorize **GROTON MEDICAL ASSOCIATES** to (please check one): **Obtain** ☐ **Release** ☐

From: **To**:

Physician Name/Practice Name | Physician Name/Practice Name

Address | Address

City/State/Zip | City/State/Zip

Telephone/Fax Number | Telephone/Fax Number

Are you (please check one):

Transferring out of Groton Medical ☐ **Yes** ☐ **No**
New Patient ☐ **Yes** ☐ **No**
Rheumatology ☐ or ☐ Primary Care

By signing below, you have specifically authorized the release of the following types of highly confidential information contained in your medical record, if any:
(NOTE: Please cross out any items below if **you do not want the information disclosed**)

Information about HIV/AIDS status
Information about genetic testing
Information about Venereal Diseases
Abortion consent forms
Mammography Records
Information about family planning services
Information about research involving controlled substances
Information related to mental health community program records
Information about treatment of substance abuse (drug or alcohol)
Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual counselor, or other allied mental health or professional human services.

If you are requesting that only a portion of your medical records be released, please describe the information to be released (i.e labs,, immunization records, diagnostic imaging report):

Signature of Patient/Personal Representative **Date**