Rutland Family Health Center
Dr Raffia Qutab
694 Main St
Holden, MA 01520
(508) 886 6500

Authorization To Disclose Medical Record Information

Patient Information

Name:_____
Address:_____
Phone Number:_____
Patient Signature:_____
Legal Guardian (if under the age of 18):_____
Date Signed:_____
Witness:_____

Release of Information

I hereby authorize Rutland Family Health Center to

☐ **Mail my records to** ☐ **Obtain my records from:**

Facility Name:_____
Attn:_____
_
Address:_____
Phone:_____
Fax:_____

Purpose of request

☐ Personal ☐ Continuing Care ☐ Transfer of Care

☐ Legal ☐ Insurance ☐ Other: _____

Information to be released:

Please be specific. Include dates of treatments if possible.

_____

_____

I understand that my health record may include general information related to my mental health, drug/alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or
Before the date this authorization was signed. I authorize the release of services for dates
From_____through_____