Williamstown
Medical
Associates 197 Adams Road, Williamstown, MA 01267 (413) 458-8182 Fax (413) 458-3140

(1) I hereby authorize_____
(Please Provide Name of Physician You Want Records From. If Other Than a Williamstown Medical Provider, Please Supply Address.)
_____

to use or disclose the following health information: ☐ Complete Record ☐ Other (Please Describe Below, Including Dates)
_____

On the list below, please initial next to any of the records you want included:

	INITIALS		INITIALS		INIITALS		INITIALS
Mental Health		Alcohol Abuse		Drug Abuse		Child Abuse	
Physical Abuse		Sexual Abuse		Venereal Disease		Genetic Testing	

In addition, if you want your HIV (AIDS) testing/treatment records released you must sign and date the line below.

_____ _____
Signature Date

(2) From the medical record of:

_____ _____ _____
Patient's Name (Please Provide Previous Name if Necessary) Date of Birth Telephone Number

_____
_____
Address Med. Rec. # (Internal Use Only)

(3) This information is to be disclosed to _____ _____
Name Telephone Number

_____
Address

For the purpose of
_____

Please Mail By_____ or Will Pick Up on_____ at: ACC WMS
Date Date (Circle One)

(4) I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

(5) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits (except in limited circumstances). I may inspect or copy any information used/disclosed under this authorization. **I will receive a copy of this authorization**.

(6) I understand this authorization may be revoked at any time by writing to the person or entity I authorized to release my information, except to the extent that disclosure made in good faith has already occurred in reliance on this authorization**. This authorization expires_____ (Insert Date or Expiration Event).**

(7) The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____ _____
Signature--Age 18 or Older Date Primary Care Physician
Parent (if minor) or legal representative (written proof of legal representation needed)

_____
Witness