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

(1) I hereby authorize **Williamstown Medical Associates** to disclose any or all of my health information,
_____ Appointments Only, _____ Written & Verbal or _____ Electronic Records

	INITIALS		**INITIALS**		**INITIALS**		**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 provided 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

(3) This information is to be disclosed to (please list additional names on back, if necessary):

_____ _____ _____
Name Telephone Number Address

_____ _____ _____
Name Telephone Number Address

_____ _____ _____
Name Telephone Number Address

For ongoing communication and/or sharing of records related to patient care.

(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. This authorization expires when revoked in writing unless otherwise indicated. **This authorization expires:_____ (Insert Date or 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.

(8) I understand and acknowledge that this authorization will allow the above individual(s) the ability to access my medical records to the same extent that I could if I were using the Patient Portal myself.

_____ _____ _____
Signature--Age 18 or Older or Legal Representative Date Provider
(written proof of legal representation needed)

_____
Witness (cannot be named above)