**AOA, Inc.**
**174 Pleasant Street**
**Attleboro, MA 02703**

**Phone: (508) 226-1809**
**Fax: (508) 226-4228**

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____
(Please Print)

Patient's Address: _____
Street City State Zip

**I, _____ do hereby authorize AOA, Inc. to release my protected health information, including copies of the medical record of the above-named patient to the following person or facilities listed below for the purposes described:**

Name of Person or Facility: _____ Telephone: _____

Address: _____ Fax: _____
Street City State Zip

## PURPOSE OF RELEASE:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Leaving AOA, Inc. ☐ Other (Specify)_____

## INFORMATION TO BE RELEASED (Please check all that apply and specify dates):

☐ ALL Medical Records _____ ☐ All Scans _____ ☐ Billing Records _____
Dates Dates Dates

## RELEASE OF INFORMATION REQUIRING SPECIFIC CONSENT: I AUTHORIZE THE RELEASE of information in my medical record in certain categories, by initialing each appropriate category I want released:

☐ Abortion ☐ Behavorial/Mental Health ☐ Rape/Sexual Assault ☐ Genetic Testing

☐ Alcohol/Abuse ☐ HIV/AIDS Results/Treatment ☐ Domestic Violence ☐ Sexually Transmitted Diseases

I understand that:

- I may revoke my authorization at any time by submitting a written notice/request to the address listed above. The revocation will be
- effective upon AOA, Inc's receipt of said written notice. Authorization may be revoked except for the following:
  - To the extent that action has been taken in reliance on this authorization before revocation is received
  - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- Once AOA, Inc. has disclosed my heath information to the recipient, AOA, Inc. does not and cannot guarantee that the recipient will not re-disclose my health information to a third party.
- I understand that this authorization will automatically **expire six (6) months** from the date listed below

**I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.**

_____ Date: _____
Signature of Patient or Authorized Representative

_____ Relationship to Patient: _____
Printed Name of Patient or Authorized Representative

Patient Requests AOA, Inc. records>>>>going out