AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

966 Park Street, Suite B-2 Stoughton, MA 02072

Phone: 781.475.5171 | Fax: 781.475.5172

I hereby authorize the release of information from the medical record of:

Patient Name: _____ DOB_____

Patient Address: _____

City _____ State: _____ Zip Code: _____

Release Information To	Information Requested From:
More Care AFC Attn: Medical Records 966 Park Street, Suite B-2 Stoughton, MA 02072 Phone: 781.475.5171	

Please Release the Following:

[ ] Summary of Medical History [ ] Current Medication List

[ ] Discharge Paperwork [ ] Other: _____

_____

Purpose of Need for Disclosure:

[ ] Start/Continued Patient Care [ ] Other_____

I understand that the information released is for the specific purpose(s) stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will remain valid and in effect for so long as I am receiving services from Century Homecare and will expire three (3) months after the last date of my receipt of services from Century Homecare unless otherwise specified.

Name of Patient or Legal Representative: _____

Signature of Patient or Legal Representative: _____ Date: _____