Mark Weiner, MD
4 Frank Leary Way
Randolph, MA 02368

MediGroup PC

Tel (781) 986-0507
Fax (866) 480-4671
mm@MediGroupPC.com

Medical Records Release and Authorization Form

PATIENT				
Last:	First:	Middle		
Address:	City:	State:	ZIP:	
Home phone:	Cell phone:	Work phone:		
DOB:	Age:	☐ Male ☐ Female		

By completing this form, I authorize the following doctor/organization to release the information from my protected patient health information record.
Further, I authorize MediGroup, PC to verbally communicate with the stated provider as it relates to my medical care.

Information to be released FROM:	Information to be released TO:
Physician/Organization:	Dr. Mark Weiner / MediGroup, P.C.
	4 Frank Leary Way
Street:	Randolph, MA 02368
City, ST ZIP:	Phone: 781-986-0507
Phone:	FAX: 866-480-4671
Fax:	Email: mm@MediGroupPC.com

This authorization covers the following dates of service: _____

INFORMATION TO BE RELEASED TO MEDIGROUP, PC:	
☐ Full medical record	☐ Records relating to the following condition(s):
☐ Physician's/nurse's notes	

Please note, this authorization is not valid unless initialed below.

_____ I hereby authorize release of protected health information pertaining to Mental Health.

_____ I hereby authorize release of protected health information pertaining to drug and/or alcohol abuse.

_____ I hereby authorize release of protected health information pertaining to sexually transmitted diseases including HIV/AIDS.

I understand that information used or disclosed as a result of this authorization may be further used or disclosed by someone who obtains such information and therefore may no longer be protected by federal privacy laws. I acknowledge that I have fully reviewed and understand the contents of this authorization form. I understand that I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. To revoke this authorization, I must mail a letter to MediGroup, PC requesting such. My signature below indicates that I hereby agree and authorize the release of patient health information.

Signature of patient or patient's representative _____ Date _____

This authorization will expire on _____ or 180 days from the date of signature if left blank.