Request of Medical Records Release

DOCTOR / FACILITY

ADDRESS

TELEPHONE

ADDRESS 2

FAX

CITY

STATE

ZIPCODE

PLEASE RELEASE MY MEDICAL RECORDS TO:

Susan Mann, M.D.
1180 Beacon Street Suite A
Brookline, MA 02446

P: 617–366–7711
F: 617–232–2055

NAME OF THE PATIENT REQUESTING:

HOME ADDRESS

OTHER NAMES USED IN THE PAST:

HOME ADDRESS 2

DATE OF BIRTH (MONTH / DAY / YEAR)

CITY

STATE

ZIPCODE

RECORDS TO BE RELEASED:

- ☐ All medical records including labs, diagnostic tests, and ultrasound scans.
- ☐ Medical records since the year ____________ .
- ☐ **HIV/AIDS:** I specifically give permission to share information in my record about my HIV/AIDs diagnosis and or treatment information. Initial here to specifically authorize its release ___________ as required by M.G.L. c.111, § 70F.
- ☐ **Genetic testing:** I specifically give permission to share information in my record about my genetics testing (excludes therapeutic genetic tests). Initial here to specifically authorize its release ___________ as required by M.G.L. c.111, § 70G.

SIGNATURE

DATE OF REQUEST