



Wynne Huang, MD

955 Main Street, Unit 306 | Winchester, Massachusetts 01890

caringforall.com | (781) 938-1888 | Fax: (781) 938-8008

Authorization for Release of Medical Records

Name: _____

Date of Birth: _____ Phone: _____

Address: _____ City, State, Zip Code: _____

I authorize **Caring for All, PC to receive** a copy of my medical records from (previous physician's name and address):

Name: _____

Address: _____

I authorize **Caring for All, PC to release** a copy of my medical records to:

Name: _____

Address: _____

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Full medical record | <input type="checkbox"/> Last EKG | <input type="checkbox"/> Any diagnostic testing |
| <input type="checkbox"/> Problem list, medication list, allergies | <input type="checkbox"/> Recent labs | |

I am aware the records may contain information on the following medical conditions and authorize release of that which I have authorized by initialization:

- | | |
|-----------------------------------|--|
| _____ Alcohol / drug abuse | _____ Treatment of mental illness |
| _____ History of venereal disease | _____ Treatment of testing of HIV / AIDS |

Signature: _____ Date: _____

This authorization is valid for six months and can be revoked by written notice.

I understand that this Authorization will remain in effect for six months or until I provide a written notice of revocation to Caring for All, PC, except to the extent that action on it has already begun. I hereby, knowingly and voluntarily, authorize Caring for All, PC to use or disclose my health information in the manner described above. I understand that once Caring for All, PC has disclosed my information to the recipient, Caring for All, PC cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable to federal and state law governing the use or the disclosure of my health information.