



Wynne Huang, MD

800 West Cummings Park, Suite 2250, Woburn, MA 01801

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

Authorization for Release of Medical Records

Name: _____ DOB: _____

Address: _____ Phone: _____

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

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

- Full medical record
- Problem list, medication list, allergies
- Any diagnostic testing
- Last EKG
- 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
- History of venereal disease
- Treatment of mental illness
- 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 6 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 discloses 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 federal and state law governing the user the disclosure of my health information.