Elena Gorlovsky, M.D., FAAP
Enmei Wang, M.D., FAAP
Jaime Lincoln, CPNP
Andrea Jacobs, CPNP
15 Richardson Avenue, Wakefield, MA 01880
Telephone: (781) 245-2203 Fax: (781) 245-7303

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

	Information Requested From:	Recipient of Information:
		Self: ☐ Other: ☐
Name:	Elena Gorlovsky, MD & Enmei Wang, MD	Name: _____
Address:	15 Richardson Avenue	Address: _____
	Wakefield, MA 01880	_____
Phone #:	(781) 245-2203	Phone #: _____

Information to be Disclosed: (Please specify) *There will be a $20.00 charge for transfer of record.*

☐ Complete Medical Record	☐ EKG Reports	☐ Physical Therapy
☐ Discharge Summary	☐ X-Ray Reports	☐ Emergency Reports
☐ Consults	☐ Laboratory	☐ Immunizations
☐ Outpatient Reports	☐ Pathology	☐ Other: _____

Protected Health Information: (Please check the following specific authorizations)
I understand that my specific consent is necessary to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment.

Drug Abuse/Alcohol	☐ I DO authorize	☐ I DO NOT authorize
HIV/AIDS Documentation	☐ I DO authorize	☐ I DO NOT authorize
Psychiatric Documentation	☐ I DO authorize	☐ I DO NOT authorize

Purpose of Disclosure: (Please specify)

☐ Age ☐ Moving/Moved ☐ Insurance ☐ Other: _____

Authorization:

I understand that:

1. This authorization is valid for 90 days from date of signature.
2. I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
3. My medical treatment cannot and will not be dependent upon me signing this authorization.
4. The medical information that is the subject of this form may not be protected by the federal privacy regulations if or when it is redisclosed by the person, group, or institution I am authorizing to receive it.
5. I have the right to receive a copy of this authorization.
6. I have the right not to sign this authorization.

_____ _____
Patient/Guardian/Representative Signature Date