Zaheen Medical Center
231 Sutton St Ste 1A North Andover, MA 01845
Phone (978) 655-1042 / Fax (978) 655-1046

Fill out all highlighted areas

Authorization to Release Information

By Signing below, you authorize Zaheen Medical Center and/or members of the office staff to release medical information to persons other than you?

YES: _____ NO: _____

Authorized Person: Relationship to you:

Authorized Person: Relationship to you:

What information may be released?

Appointments	Yes_____	No_____
Financials/Billing	Yes_____	No_____
HIV/STD Results	Yes_____	No_____
Mental Health Records	Yes_____	No_____
Drug and Alcohol Abuse Treatment	Yes_____	No_____
Medications	Yes_____	No_____
Lab Results	Yes_____	No_____
X-Ray Reports	Yes_____	No_____

I understand that as part of my continuing healthcare, my physician maintains medical records which contain my health history, symptoms, examination test results, diagnoses and treatment plans, to be used as a bash for planning my care and treatment, and that this information may be released to my other phy1iciana and healthcare providers,

I understand that I have the right to request restrictions as to how my medical record may be used or disclosed.

I understand that my physician keeps on premises a copy of the “Authorizations to use or Disclose Protected Health Information" which provides a more complete description of the uses and disclosures of my medical record, and that l have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me upon my request.

I understand that my physician has the right to change this policy and that I will be notified in writing prior to any changes taking effect.

I understand that this document is a part of my permanent medical record, and that I may make change regarding the disclosure of my health information at any time and. that I need to notify my physician in writing of these changes.

Patient Name: _____ Date of Birth: _____

Patient’s Signature: _____ Date: _____