Please upload this page to the portal, or fax to 781-890-2177
If you have questions please call 781-890-2133

Records Release

Print Name:_____Date of Birth:_____
Home Address Street:_____Apt#_____
City:_____State:_____Zip:_____
By Signing this release form, I authorize **Boston Sports & Shoulder Center**, to send a copy of my medical records **to the following:**

Share to:

Name or Office: _____

Street:_____

Apt#:_____City:_____

State:_____Zip:_____

Phone: _____

Fax: _____

Purpose:

- ☐ Medical care
- ☐ Insurance
- ☐ Legal
- ☐ Personal
- ☐ School
- ☐ Other (please specify): _____

Send via:

- ☐ Portal
- ☐ Fax provided
- ☐ Mail paper copy address provided

Medical Records to be sent (please select):

- ☐ **ALL** of my medical records (excluding imaging done in the Waltham office)
- ☐ Imaging done in the Waltham office **ONLY***
- ☐ **ONLY** the following medical records:_____

Special medical records to be sent (please check any/all the apply):

- ☐ Drug and alcohol abuse records
- ☐ Mental health records
- ☐ HIV/AIDS records
- ☐ Sexual abuse/ assault and domestic violence records
- ☐ Sexually-transmitted disease records

I understand and agree that:

- Boston Sports & Shoulder Center cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Boston Sports & Shoulder Center may or may not protect this information once it has been released to the recipient.
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except: if Boston Sports & Shoulder Center has already processed the request (for example, once information is released, it will not be retrieved) if I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire 6 months from the date signed unless otherwise specified:_____
- I understand that if Boston Sports & Shoulder Center maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

Patient Signature: _____Date:_____
Print Name: _____
When a patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.
Signature of Legal Representative: _____Date:_____
Print Name: _____Relationship to patient:_____

For Internal Use Only: Information Released/Reviewed By:_____ Date:_____
Picked up by:_____ Pick-up Identification: ☐ License ☐ State ID ☐ Passport ☐ Other Photo ID_____

*Imaging done at New England Baptist Hospital, Boston or Dedham, needs to be requested via: https://nebhpatient.ambrahealth.com/access