Authorization for Release of Protected or Privileged Health Information

Patient Name:_____ Date of Birth:_____

Patient Address:_____ (street)

_____ (city)

_____ (state) _____(zip)

Telephone: _____

I, _____, do hereby authorize my **current primary care physician**, _____ to release my protected health information including copies of my medical records for the past 3 years, reports, including lab reports, radiation, x-ray reports and scans, to my new primary care physician:

Geoffrey M. Burns, MD
Renaissance Family Medicine of Wellesley
332 Washington Street, Suite 200
Wellesley Hills, MA 02481
Phone: 781-235-4088 **Current PCP fax**#_____

_____ Date: _____
(Patient's signature)

_____
(Print name clearly)

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian or other legal representative is required:

_____ Date: _____
(Signature of parent or legal representative)

_____ _____
(Print name clearly) *(Relationship to patient)*