BERKSHIRE MEDICAL GROUP, P.C.

777 NORTH STREET, SUITE 207
PITTSFIELD, MA 01201
OFFICE: 413-499-8510 FAX: 413-499-8549

HIPAA PATIENT RELEASE OF INFORMATION AUTHORIZATION FORM

Patient name: (print)	Date
Date of Birth:	Telephone Number:
Address:	Zip:

Provide medical records from:	To:
Name:	Berkshire Medical Group, PC
Address:	777 North Street, Suite 207
City, State, Zip:	Pittsfield, MA 01201
Telephone Number:	Office: 413-499-8510 fax: 413-499-8553

Please check one reason for request:	
☐ Patient leaving practice: Y☐ N☐	☐ Insurance/Billing
☐ Personal	☐ Attorney
☐ Medical Treatment	☐ Part-time resident: (need records for continuity of care, not transfer from practice)

Please read the following statements:

- The law states we are unable to release information from other physician˘s offices that may be in your medical record. This information must be obtained from the originating physician.
- I authorize Berkshire Medical Group, P.C. to use, disclose or receive my health information for reasons of treatment, payment and/or health and business operations.
- I understand that Berkshire Medical Group will not condition my treatment on whether I provide authorization for the requested use, disclosure or receipt.
- I understand that I may revoke this authorization at any time by notifying Berkshire Medical Group in writing: however, such revocation does not affect any actions taken by Berkshire Medical Group before receipt of written revocation.
- I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and man no longer be protected by federal privacy regulations or other applicable state or federal laws.
- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.
- I understand that this authorization will expire one year from ____
- I understand that this authorization is voluntary and that I have the right to refuse to sign this form.
- I understand that I must present a picture ID when picking up my records.

____ _________________

Signature of Individual/Personal Representative of the Individual Date
(We need documentation of a personal representative)

____ _________________

Signature of Witness Date