CONSENT FOR THE RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

I hereby authorize …….... ("the Medical Practice") to release and /or transfer **to EASTERN and WESTERN MEDICAL CENTER, PLLC**, all records, opinions, reports, x-rays, laboratory tests and analyses, photostatic copies, abstracts or excerpts of any medical records or other information of any kind relating to the undersigned in the possession of the Medical Practice (hereinafter collectively referred to as "Confidential Health Care Information"), including those results related to tests for HIV, for the purposes of coordinating my health care, and/or coordinating the payment of claims with my health insurer. Provided, however, that this Consent for the Release of Confidential Health Care Information shall not apply to Confidential Health Care Information maintained in connection with the performance of any federally assisted alcohol and drug abuse program.

I understand that I may withdraw this consent for the release and/or transfer of my Confidential Health Care Information in writing at any future time.

PRINT NAME:_____ DATE_____

SIGNATURE:_____

DATE OF BIRTH:_____

SOCIAL SECURITY #:_____

PLEASE MAIL OR FAX the records to:
EASTERN and WESTERN MEDICAL CENTER, PLLC,
381 Park Avenue
Worcester, MA 01610-1026
Fax (508) 792-0400