TristanMedical
RAYNHAM CARE CENTER
Phone 508-880-0012 FAX: 508-880-0256
675 Paramount Drive, Suite 203 Raynham MA 02767

Authorization for the Release of Medical Records

Step 1: Patient information PLEASE PRINT

_____ _____
Patient's Name Date of Birth

_____
Telephone

_____
Address

State Zip

Step 2: Where are your medical records now? PLEASE PRINT

_____ _____
Doctor's name Telephone/Fax

_____ _____
Street City State Zip

Step 3: To whom do you wish to release your records to? *We do not accept double sided records or records on a disc*

Tristan Medical Raynham Care Center 508-880-0012/ 508-880-0256
Doctor's name Telephone/Fax

675 Paramount Drive, Suite 203 Raynham MA 02767
Street City State Zip

Step 4: What records are being requested?

- ☐ Last two years of office visits
- ☐ Most Recent Mammogram
- ☐ Most Recent Pap Smear
- ☐ Most Recent Colonoscopy
- ☐ Most Recent EKG
- ☐ Recent Labs/Imaging (One Year)
- ☐ Vaccine History, Medication History and Allergies
- ☐ Psychiatric information
- ☐ AIDS/HIV information of Test Results
- ☐ Social Services Notes
- ☐ Drug/Alcohol abuse
- ☐ Sexual, Physical abuse
- ☐ Sexually Transmitted Disease
- ☐ Other: _____

Step 5: Your Signature and Date

By signing this release, I hereby authorize the above listed provider to release my medical records to Tristan Medical. This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization is required for a different doctor or entity.

_____
Patient Signature Date

_____
Witness Signature Date

_____
Parent/ Guardian Signature Date