TristanMedical
NORTON CARE CENTER
Phone 508-824-0243 FAX: 508-880-1906
184 W Main Street Norton, MA 02766

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 Norton Care Center — Doctor's name
508-824-0243/ 508-880-1906 — Telephone/Fax

184 W Main Street — Street
Norton — City
MA — State
02766 — 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 _____