

Megan Hudson, DC
52 Maple Street
Florence, MA 01062
Phone (413) 695-2738 Fax (413) 584-0708

**AUTHORIZATION TO OBTAIN
and/or FOR RELEASE OF MEDICAL RECORDS**

Patient's Name: _____ Date of Birth: _____

Address: _____ City _____ State _____ Zip _____

Telephone: (H) _____ (W) _____

I hereby authorize Dr. Megan Hudson to obtain / release any and all medical records concerning my care from any physician, hospital, or other health care provider providing medical care to me at any time.

I also authorize Dr. Megan Hudson to release any and all records concerning my care to Medicare, any insurance company, third party administrator, or managed care entity.

This medical record may contain information pertaining to drug or alcohol abuse, HIV testing and/or AIDS diagnosis or treatment, or mental health treatment.

I understand that I may, in writing, revoke this consent at any time except where information has already been released.

Patient's Signature Date

Witness Signature Date

I have received a copy of Dr. Megan Hudson's *Notice of Privacy Practices*.

Patient's Signature Date

OVER →

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS /
FAMILY MEMBERS**

I authorize Dr. Megan Hudson to release any and all information concerning my medical care to the following individuals:

Name: _____ Date: _____

Relationship to patient: _____ Patient's Signature: _____

Name: _____ Date: _____

Relationship to patient: _____ Patient's Signature: _____

STATEMENT TO REVOKE CONSENT

I hereby revoke all statements as designated on this form. (Front of document to be crossed out.)

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____