Yuko Family Medicine
WE ARE HERE FOR YOU

AUTHORIZATION TO RELEASE INFORMATION

Name:_____DOB:_____Phone #: _____

PLEASE OBTAIN INFORMATION FROM:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

Phone:_____Fax:_____

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PLEASE SEND INFORMATION TO:

Yuko Family Medicine
Dr Yuko McColgan
1180 Beacon Street Suite 3B
Brookline MA 02446
Phone: 617-566-9856 Fax: 617-232-8086

I authorize the following information to be disclosed to Yuko Family Medicine: (Please check below)

_____ Entire Record and Vaccine History including Behavioral Health and HIV
_____ Specific Information: _____

Reason for Disclosure of this authorization: (Please check)
___Continuing Care __Job
___I will no longer be a patient at your Clinic/Facility/Practice
___Legal ___ Other: _____

PATIENT INFORMATION:
- I understand that I have the right to withdraw this authorization.
- I understand that I do not have to sign this authorization to receive treatment.
- This request shall remain in effect for 90 days unless specifically revoked in writing; however, such revocation does not affect any actions taken by Yuko Family Medicine before receipt of the revocation.
- Failure to fill this authorization out in its entirety and sign will result in a delay and MUST be read completely. I understand that signing this authorization does not cancel any rights I have under the state/federal laws.

Signature of Patient:_____Date:_____