Shrewsbury Medical Group

415 Boston Turnpike, Suite 105
Shrewsbury, MA 01545
Phone: (508) 845-8200
Fax: (508) 845-8300
www.shrewsburymedicalgroup.com

AUTHORIZATION OF RECORD RELEASE

Last Name :_____, First Name:_____, Date of Birth _____

Address: _____

Authorization and request is hereby made for my medical record to: □ release from; □ receive

Robert Shepherd D.O.
415 Boston Turnpike Suite 105
Shrewsbury MA, 01545

Authorization and request is hereby made for my medical record to: □ release from; □ receive

Physician Name:_____, Phone#_____Fax_____
Address:_____

The following information is requested:

( )	Physical Exam	**( )**	Progress Notes
( )	Consultation	**( )**	Medication records
( )	Laboratory	**( )**	Occupational health
( )	X-ray	**( )**	Worker injury reports
( )	EKG	**( )**	Physical therapy reports
( )	Pulmonary Function Testing	**( )**	Immunization records

( ) Other specific Progress Notes: _____

Does this include psychiatric, chemical dependency and/or Aids-related information?

( ) YES **( )** NO
( ) Specific for Psychiatry Consultation Notes
( ) Specific for drug testing results

_____
Signature of Patient or Legal Representative Date

_____
(IF NOT SIGNED BY PATIENT, SPECIFY RELATIONSHIP TO PATIENT)