



**NORTH PROVIDENCE PRIMARY CARE**

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**AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS**

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_  
\_\_\_\_\_ SSN: \_\_\_\_\_

Transfer the following information TO: \_\_\_\_\_  
\_\_\_\_\_ Receive the following information FROM: \_\_\_\_\_  
\_\_\_\_\_

- Complete Records
- Consultation Notes
- Laboratory Studies
- X-Ray Reports

This authorization includes allowing the transfer of information regarding:

- AIDS (Acquired Immunodeficiency Syndrome)
- HIV (Human Immunodeficiency Virus)
- Psychiatric Disorders
- History of treatment for drug or alcohol use

I understand this authorization may be revoked at any time prior to an actual release of records made in good faith that occurred in reliance of this authorization. This authorization will automatically expire in 90 days from the date below.

**THIS AUTHORIZATION DOES NOT ALLOW AN AGENCY RECEIVING RECORDS FROM FURTHER DISTRUBITING THEM WITHOUT THE ADDITIONAL WRITTEN CONSENT OF THE PATIENT**

Signed: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Witness: \_\_\_\_\_ Date Signed: \_\_\_\_\_