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Tel: (617) 777-4080 · Fax: (617) 224-4306
E-mail: enhancedmedical@gmail.com

Instructions for Authorization for Use and Disclosure of Protected Health Information Form

Your previous medical history is essential for us to provide you with optimal healthcare. **On this page**, please provide us with the contact information of any previous physician or healthcare provider from whom you've received significant care. **Please include as much information as you can.** If you need more space, please feel free to use the back of this page.

On the authorization form, please complete **sections 1 and 6 only**. Please do not complete the other sections, as we need to keep a blank copy in your file in case we need to obtain your records from elsewhere and you are unavailable to provide your signature.

Thank you very much!

- Enhanced Medical Care

Provider #1:

Name/Facility: ____ **Specialty:**__________________________

Approximate Dates Seen: ___________________ **to** _____________________

Address: ____

Phone # (_______) _________-_____________ Fax # (_______) _________-______________

Provider #2:

Name/Facility: ____ **Specialty:**__________________________

Approximate Dates Seen: ___________________ **to** _____________________

Address: ____

Phone # (_______) _________-_____________ Fax # (_______) _________-______________

Provider #3:

Name/Facility: ____ **Specialty:**__________________________

Approximate Dates Seen: ___________________ **to** _____________________

Address: ____

Phone # (_______) _________-_____________ Fax # (_______) _________-______________