EDWARD M. KENNEDY
Community Health Center

Completed By (For Office Use Only):
Printed Name: ________________ Dept: ____________ Date: __________

Authorization to Disclose Health Record Information

Patient Information

Patient's Name: ____ Pt ID #: ______________________

Patient's Address: ____ D.O.B.: ______________________

City: __________________________ State: ______________ Zip: ________ Phone #: ______________________

Release Information *I Hereby Authorize Edward M. Kennedy Community Health Center to:*

☐ **Give my Health records to:** ☐ **Obtain my Health records from:** ☐ **Give a copy to myself**

Name/Facility: ____ Attention: ____________________________

Address: ____ Phone: ________________________________

City: ______________________________ State: ________________________ Zip: _________________

Purpose of request: ☐Personal ☐Continuing Care (referral/2nd opinion) ☐Transfer of care (new Physician) Reason for Transfer: ___
☐Legal ☐ Insurance ☐Other: ____

I would like my record in the following format: ☐ Paper ☐ Electronic

---

Information to be Released: ***Please be specific–****include dates of treatment and provider's name if applicable*

☐Complete Record and Date Range: __________________ to _______________
Or:

____ Date(s) of treatment: ____________________________

Statutorily Protected & Sensitive Information
Your informed consent is required to release records containing the information below. Please check and initial those categories which you are authorizing to be released.

☐Mental Health	Initials: ________	☐ Depression/Anxiety	Initials: _______
☐Alcohol/Substance Abuse	Initials: ________	☐ Domestic/Sexual Assault	Initials: _______
☐HIV	Initials: ________	☐ Genetic Testing	Initials: _______
☐Sexually Transmitted Disease(s)	Initials: ________	☐ Abortion	Initials: _______

I understand that I have the right to revoke this authorization at any time by providing a written statement to the Health Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand, unless otherwise revoked or specified, this authorization is valid for 12 months.

Please specify an expiration date if other than 12 months: ______________________________

I understand that authorizing the disclosure if this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Signatures

Patient/Legal Representative Signature: ____ Date: __________

If signed by a Legal Representative, Relationship to Patient: ______________________________

Witness Signature: ____ Date: _________

Witness Printed name: ____