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

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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 of 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: _____