**Authorization to Disclose Health Record Information**

**Patient Information**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Date Range: from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Records sent on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ by site staff Framingham Milford Worcester Medical Records Department*

Reviewed 09/28 GL-MR-103.15-F