Island Health Care
A FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER

AUTHORIZATION TO REQUEST AND/OR DISCLOSE HEALTH INFORMATION

245 EDGARTOWN VINEYARD HAVEN ROAD, EDGARTOWN, MA, 02539
TEL: 508-939-9358, FAX: 508-939-8644

Patient Name:_____Date of Birth:_____MRN#: _____

Address: _____

Phone number:_____Email: _____

I give my permission to the facility below to release the following information if present in my record:

Section 1. Release from: The individual or organization below may release my health information to recipient identified in Section 2.	**Section 2. Release to**: The information identified below may be released to the following individual(s) or organization(s):
Name: _____ Address: _____ _____ Phone: _____ Fax: _____	Name: _____ Address: _____ _____ Phone: _____ Fax: _____ Requesting provider: _____

Section 3. The information to be used or disclosed is listed below within the time frame specified in the "date range" column (ex. 2020-2022). Check the appropriate box(es) and include other information where indicated:

Type of information (Medical Records)	**Date range**	**Type of information (Behavioral Health Records)**	**Date range**
☐ The entire record (all information)		☐ The entire record (all information)	
☐ Visit notes/Care Plan		☐ Visit notes, Diagnosis, Assessment, Treatment Plan	
☐ Medications		☐ Medications	
☐ Problem list		☐ Problem list	
☐ Immunization records		☐ Program Discharge Summary	
☐ Specialty physician consult notes		☐ Social, education, family, employment & other assessments, intake sheet, individual or family service or education plan, goal attainment	
☐ All diagnostic reports (lab, x-ray, etc.)			
☐ Mammography report		☐ Other: (Describe as specifically as possible)	
☐ Pap Smear report			
☐ Colonoscopy report			
☐ Hospital records (Discharge summary, ED Records, etc.)			
☐ Other: (Describe as specifically as possible)			

Section 4. Purpose of use/disclosure. The information selected in Section 3 will be used for the following purpose(s):

☐ My personal records

☐ Self-referral

☐ Legal purposes

☐ Continuity of Care (Sharing with other health care providers in verbal and/or written format as needed)

☐ Changing Primary Care Provider. Please list the reason for changing below (ex. moving, unhappy with current care, not satisfied with availability of appointments, insurance changes): _____

☐ Other (please describe): _____

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Please read very carefully: Check below to give permission to release the information below if present in your record. You must check at least one box (And if you don't want any of this information released, select "None of the above.")

☐ HIV/AIDS information (Patient authorization is required for each release request).

☐ Sexually Transmitted Diseases (STD).

☐ Alcohol and substance use disorder records protected by federal confidentiality rule 42 CFR part 2. (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2). This consent may be revoked upon written request.

☐ Details of mental health diagnosis and/or treatment provided by a Psychiatrist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician. I understand that my permission may not be required to release my mental health records for payment purposes.

☐ Confidential communications with a Licensed Social Worker.

☐ Details of Domestic Violence Victims' Counseling.

☐ Details of Sexual Assault Counseling.

☐ None of the above.

Authorization Statements/Signatures:

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the HIPAA Privacy Rule is no longer protected by Island Health Care.
2. I understand that Island Health Care will not condition the provision of treatment or payment on the provision of this authorization. My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form.
3. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to an Island Health Care staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
4. I understand that my revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization is valid for Protected Health Information:
   ☐ A one-time disclosure expires in 60 days ☐ Ongoing disclosure that expires upon written revocation.
   ☐ Expire in 1 year ☐ Expire in 2 years ☐ Expire on date (specify): _____
6. How would you like to receive records?
   ☐ Paper ☐ CD
   ☐ Fax
7. I have carefully read and understood the above, have had any questions answered to my satisfaction, and do herein expressly and voluntarily authorize the disclosure of the above information about/ for medical records to the recipient listed in Section 2.

_____ _____
Signature of Patient or Personal Representative Effective Date

_____
Print Name

_____
Personal Representative's Title (e.g. Guardian, Executor of Estate, Health Care Power of Attorney)

If a patient's personal representative has signed this form, a copy of legal paperwork verifying that personal representative MUST accompany the request. Exception: parent or legal guardian authorized to sign for a patient under the age of 18.

For Internal Use Only

Date request received:_____ Received by: ☐ Mail ☐ Email ☐ Dropped off in person.

Date released:_____ Information released/ reviewed by: _____

Records sent by: ☐ Mail ☐ Fax ☐ Picked up in person ☐ Direct Messaging

Revocation

Date Revoked: _____

Initials of Privacy Officer: _____