AUTHORIZATION TO REQUEST AND/OR DISCLOSE HEALTH INFORMATION

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

Patient Name: ______________________________ Date of Birth: ___________ MRN# _______________

Address: ____

Facility name (obtaining from): ____
_

Fax:_______________________________________ Phone: ____

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

1. **Type of information:** The type of information to be used or disclosed is as follows (check the appropriate circle(s) and include other information where indicated):

○ The entire medical record (all information)
○ Clinic visit notes/Care Plan
○ Physician and professional consult progress Notes
○ Diagnostic reports (lab, x-ray, etc.)
○ Hospital records (Discharge summary, ED records, etc.)
○ Medication and treatment records
○ Other: (Describe as specifically as possible)

____

Please read very carefully: Check below to give permission to release this information if present in your record:

○ HIV/AIDS information (Patient authorization required for each release request)
○ Sexually Transmitted Diseases (STD)
○ Alcohol and Drug Abuse Records Protected by Federal Confidentiality rules 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

2. **Recipient of information** – The information identified above may be released to the following individual(s) or organization(s):

Name: _______________________________
Facility: _____________________________
Address: ____________________________
____
____

Phone: _______________________________
Fax: _________________________________
Mass Hiway Direct address (if any):
____

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3. **Purpose of use/disclosure -** This information described on the previous page will be used for the following purpose(s):
   - ○ My personal records
   - ○ Sharing with family and friends (named on front)
   - ○ Self-referral
   - ○ Legal purposes
   - ○ Changing Primary Care Provider
     * What is the reason for changing?
     ____
     ____
   - ○ Continuity of Care (Sharing with other health care providers as needed)
   - ○ Other (please describe):
     (ex: insurance changes; availability of appointments; moving)
     ____

Authorization Statements/Signatures:

4. 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 protect by Island Health Care.
5. I understand that the Facility 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.
6. 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 a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
7. 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.
8. This authorization is valid for Protected Health Information:
   ☐ A onetime disclosure expires in 60 days ☐ Ongoing disclosure expire upon written revocation.
   ☐ Expire in 1 year ☐ Expire in 2 years ☐ Expire on date (specify): _____________________
9. How would you like to receive records?
   ☐ Paper ($0.15 per page + Postage if need it mailed) ☐ CD ($7.00 flat rate) ☐ Fax ($0.15 per page)
   ☐ Free Electronic transfer via "**Mass Hiway Direct Messaging**" (Only available for recipient with active direct Address. Please confirm with recipient before selecting this option)
10. I have carefully read and understood the above, have had any questions answered to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about/ for medical records of my condition to recipient.

____ ___________________
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)

** Other than the patient's signature, a copy of legal paper work verifying the patient's personal representative MUST accompany the request. Exception: parent or guardian authorized to sign for 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 Official___________