GENERAL AUTHORIZATION TO DISCLOSE PROTECTED HEATH INFORMATION

Patient Name _____ Date of Birth _____/_____/_____

Medical Record # _____

I _____ authorize the use or disclosure of the above named patient's Protected Health Information to:

ISLAND HEALTH CARE
245 Vineyard Haven Road
P.O. Box 9000
Edgartown, MA 02539
Phone: (508) 939-9358 Fax: 508-939-8644

I authorize use or disclosure of the following information: (check where applicable):

- o Entire record
- o Clinic visit notes
- o Lab results
- o X-ray and imaging reports
- o ER visit(s), Test Reports, Discharge Summary: _____

Please answer YES or NO to each of the following questions to indicate if we may release the information below (if it is in your medical record):

□ Yes □ No HIV test results.
□ Yes □ No Alcohol and Drug Abuse Records Protected by Federal Confidentiality rules 42 CFR part 2. This consent may be revoked upon oral or written request.
□ Yes □ No Details of Mental Health Diagnosis and/ or Treatment provided by a Psychiatrist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician.
□ Yes □ No Confidential Communications with a Licensed Social Worker
□ Yes □ No Detail of Domestic Violence Victims' Counseling
□ Yes □ No Detail of Sexual Assault Counseling

I understand that:

. I may withdraw my authorization at any time by submitting a written request to Island Health Care. Authorization may be withdrawn except for the following:
- to the extent that action has been taken in reliance on this authorization.
- if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

. I may refuse to sign this authorization. If I refuse to sign it, my treatment, payment, health plan enrolment, or eligibility for benefits will not be affected.

. Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners Health Care.

. I understand that this authorization will automatically expire in 6 months, unless otherwise specified ____

I have carefully read and understood the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about/ for medical records of my condition to Island Health Care.

_____ _____/_____/_____
Signature of individual/ personal representative Date

_____ _____/_____/_____
Signature of Witness Date