Island Health Care

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

245 Vineyard Haven Road. Edgartown, MA. 02539

Tel: 508-939-9358 Fax: 508-939-8644

Name: ____ Date of Birth: _______________

I authorize Island Health Care to release the health information indicated below;

- Entire record
- Partial records from date ______________________ to date ______________________
- Other(s): ____

  ____

To the recipient named below.

Name/Facility: ____

Address: ____

____

Fax# ___________________________________ Phone# _________________________________

Reason for Disclosure: ☐ Exchange health information ☐ Changing Primary Care Provider
☐ Other ____

Would you like a: ☐ Paper copy ($0.15 per page + $5.95 postage if need it mailed) or
☐ CD ($7.00 flat rate)

I understand that this may include treatment for physical and mental illness, alcohol/drug abuse, and or HIV/AIDS test results or diagnoses.

This consent is subject to renovation at any time except to the extent the action has taken thereon. This authorization and consent will expire in sixty days from the date of authorization written below. I understand that the recipient of my health information may be charged for the service of releasing medical information. Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the recipient my no longer be protected by law.

____ _____/_____/_____

Signature of Patient/ Patient's Personal Representative* Date Signed

*If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (i.e. court appointed guardian, durable power of attorney for health care). Exception: parent authorized to sign for patient under the age of 18.