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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

LAST *FIRST* *MIDDLE*

Home Address: _____ **Home Phone**: _____

_____ **Cell Phone**: _____

_____

Date of Birth: _____

SPECIFY INFORMATION TO BE DISCLOSED:

(e.g., all records, records between certain dates of treatment)

_____

_____

_____

RECIPIENT:

Name of person or class of persons to whom the Practice may disclose my health information:

_____

Address of the recipient or where my health information shoulder be delivered:

_____

TERM:

This Authorization will remain in effect (*please check one of the following*):

☐ From the date of this Authorization until the _____ day of _____, 20 _____

☐ Until the following event occurs: _____

☐ Other: _____

PURPOSE OF RELEASE:

By my signature below, I hereby authorize the Practice to use and/or disclose to the Recipient my health information for the term of this Authorization for the following specific purpose(s):

(*"at the request of the patient" is sufficient if the patient is initiating this Authorization*)

_____

_____

ACKNOWLEDGMENTS:

- I understand that I am responsible for paying the fee that the Practice charges for the copy of the information that I have requested, whether I have authorized the Practice to release such information to me or to another Recipient identified above.
    - $10 for a hard copy of information that is maintained by the Practice in hard copy.
    - Up to $6.50 for an electronic copy of information that is maintained by the Practice electronically
    - Free of charge for MassHealth patients
- I understand that once the Practice discloses my health information to the Recipient, the Practice cannot guarantee that the Recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment by the Practice is for the sole purpose of creating health information for disclosure to the Recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.
- I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice at the address listed above. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.
- I may contact the Practice by mail and/or telephone at the address and phone number listed above.
- I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Practice to use and/or disclose my health information in the manner described above.

_____ _____

Signature of Patient Date

If the patient is a minor or is incapacitated (physically or mentally), provide the following signature:

_____ _____

Signature of Parent/Guardian/Personal Representative Date

_____

Description of Relation to Patient

*** **PLEASE COMPLETE THE FOLLOWING PAGE REGARDING HIGHLY COFIDENTAL INFORMATION** ***

MY HIGHLY CONFIDENTAL INFORMATION

By signing below, I specifically authorize the use and/or disclosure of the following types of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization:

- Information about HIV/AIDS status
- Information about genetic testing
- Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, or allied mental health professional or human service professional.

- Information about treatment of substance abuse (alcohol or drug)
- Information about venereal disease(s)
- Information about family planning services
- Information related to mental health community program records

- Information about research involving controlled substances
- Abortion consent form(s)
- Mammography records
- If I am an emancipated minor, information about my treatment and diagnosis for which I have consented as an emancipated minor (except that this information shall not be disclosed to my parents)

I have struck any and all information listed above that I do not want the practice to disclose.

_____ _____

Signature of Patient Date

If the patient is a minor or is incapacitated (physically or mentally), provide the following signature:

_____ _____

Signature of Parent/Guardian/Personal Representative Date

_____

Description of Relation to Patient