



**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 Relationship to Patient

**\*\*\* Please complete the following page regarding Highly Confidential Information. \*\*\***

**MY HIGHLY CONFIDENTIAL 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:

<ul style="list-style-type: none"><li>• information about HIV/AIDS status</li><li>• information about genetic testing</li><li>• information about treatment of substance abuse (alcohol or drug)</li><li>• information about research involving controlled substances</li></ul>	<ul style="list-style-type: none"><li>• information about venereal disease(s)</li><li>• information about family planning services</li><li>• abortion consent form(s)</li><li>• mammography records</li><li>• mental health information (other than notes prepared by a mental health provider)*</li></ul>	<ul style="list-style-type: none"><li>• 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)</li></ul>
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*I have struck any and all information listed above that I do not want the Practice to disclose.*

\* Notes prepared by a mental health provider (e.g., social worker, psychologist, psychiatrist) can be released only with a separate, signed Mental Health Authorization Form.

\_\_\_\_\_  
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 Relationship to Patient