UMASS MEMORIAL HEALTH

# AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION



☐ Community Healthlink ☐ HealthAlliance-Clinton Hospital ☐ Harrington Hospital ☐ Marlborough Hospital ☐ UMass Memorial Medical Center

☐ UMass Memorial Medical Group | Location: _____ ☐ Harrington Physicians | Location: _____

Please print all information clearly in order to process your request in a timely manner.

**PATIENT INFORMATION**

Patient Name: _____

Date of Birth: _____ Medical Record #: _____

Street Address: _____ P.O. Box / Apt. # / Suite #: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____

**I hereby authorize the entity selected above, its employees, and/or agents, to (SELECT ONE):**

☐ **Request & Receive** information **from** the health care provider/organization specified below.

☐ **Release** information from the medical record of the above named patient **to** the recipient specified below.

☐ Check here if the records are to be mailed to the patient at the above address, otherwise complete the information below:

Name: _____

Street Address: _____ P.O. Box / Apt. # / Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____

**THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:**

☐ Appointment with Specialist ☐ Attorney/Legal Case ☐ Verbal Communications

☐ Transferring Care to New Provider ☐ Disability/Insurance Application/Claim ☐ Personal Use

☐ Caregiver ☐ **OTHER (specify):** _____ ☐ Pre-employment

**PLEASE COMPLETE THE INFORMATION BELOW (Choose One):**

**Individual Visit(s).** Please check either Abstract or Entire Visit Date box. Your release will include an:

☐ **Abstract of Visit Date.** Includes key elements of a specific visit date(s) including: reports, diagnostic testing (labs, x-rays, EKGs, PFTs, medication reconciliation list, allergies and provider's transcribed reports). An abstract contains the most commonly requested information and is less expensive.

☐ **Entire Visit Date.** Includes any and all documentation related to a specific visit date(s). ***Please include the date of service.***

*Date(s) From:*_____ *Through:* _____

**Specific Services.** If you wish to receive ONLY copies of specific service(s), please check ONLY the report type(s) that you are requesting and provide the date/range (when the services occurred) on the line below.

*Date(s) From:*_____ *Through:* _____

| | |
|---|---|
| ☐ Consultations | ☐ Pathology Report(s) |
| ☐ Discharge Summaries | ☐ Radiology Reports |
| ☐ Emergency Service Records | ☐ Radiology Images |
| ☐ Immunization Records | ☐ Rehabilitation: Physical Therapy, Occupational Therapy, Speech Therapy |
| ☐ Laboratory Reports (blood tests) | ☐ Other (specify): |
| ☐ Office/Clinic Notes for _____ | ☐ Other (specify): |
| ☐ Operative/Procedure Report(s) | ☐ Other (specify): |

**PROTECTED UNDER STATE OR FEDERAL LAW**

I understand that my health record may include information related to my mental health, alcohol/substance use disorder, sexual assault, sexually transmitted diseases, abortion, genetic testing, HIV/AIDS, domestic violence, or other information I may consider sensitive. **You must check the box next to the types of content below or that information will NOT be released.**

☐ Abortion - Consent Forms or Court Orders ☐ Genetic Screening Test Results ☐ Sexual Assault Counseling

☐ Domestic Violence Counseling ☐ HIV/AIDS Test Results ☐ Sexually Transmitted Diseases

☐ Details of Mental Health Diagnosis and/or Treatment Provided by a Psychologist, Psychiatrist, Mental Health Clinical Nurse Practioner, Licensed Mental Health Counselor, and Licensed Social Worker

☐ Alcohol/Substance Use Disorder



**Please Continue on Reverse Side**

**I UNDERSTAND THAT:**

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- Per the Joint Notice of Information Practices, I have the right to inspect or request copies of my medical records. Arrangements must be made to inspect my medical record on-site; please contact the Health Information Management Department (information below).
- Any disclosure carries the potential for unauthorized re-disclosure. I release UMass Memorial Health Care and its entities from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke this authorization at any time by presenting a written request to Health Information Management at the address below. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- My alcohol/substance use disorder records may be protected under the Federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires as indicated in the "Expiration of Authorization" section of the form below. (If you do not know whether this is applicable to your records, please contact your provider's office or the Privacy Hotline at 508-334-5551.)

**EXPIRATION OF AUTHORIZATION:**

Unless otherwise revoked this authorization will expire on the following date, event or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

## Requested Format for Receipt of Medical Records

***Copies generally available within 10 business days dependent upon records requested.***

***SELECT ONE OPTION BELOW:***

| PICK-UP | MAIL | PATIENT PORTAL | FAX | Email |
|---|---|---|---|---|
| ☐ Paper Copies<br>☐ CD<br>☐ Flash Drive<br>Location: _____ | ☐ Paper Copies<br>☐ CD<br>☐ Flash Drive<br>*Over 100 pages will default to CD* | ☐ When available and only if patient has activated his/her account | ☐<br>Fax: _____<br>50 page limit | ☐<br>Email Address: _____ |

**COPY FEE:** *Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. At no time will the cost-based fees exceed Massachusetts law (MGL Chapter 111; Section 70).*

***If you would like to have someone other than you (the patient) pick up your medical record, please provide their name and relationship:**

Name: _____ Relationship: _____

*****A Picture ID is Required When Picking Up Copies of Medical Records.*****

**I have completed all sections of this form. I have read and understand the above statements, and authorize the disclosure of the information requested on the reverse side of this form.**

_____ _____ _____
Signature of Patient/Parent/Legal Representative* Printed Name Date

Signer's Relationship to Patient:_____

****If signing as a legal representative, also provide appropriate paperwork to support status.***

**For questions, please contact the applicable facility below or the medical practice where you receive care.**

**UMass Memorial Health**
C/O Health Information Management
67 Millbrook Street, Suite 200
Worcester, MA 01606
Tel 508-334-5700 opt. 1
Fax 508-334-9717

**UMass Memorial Medical Group**
C/O Community Practices
367 Plantation Street
Worcester, MA 01605
Tel 508-334-1438
Fax 508-334-1448

**UMass Memorial-Community Healthlink**
C/O Compliance Department
72 Jaques Avenue
Worcester, MA 01610
Tel 508-860-1016
Fax 508-752-1379

****A copy of completed authorization must be given to patient.****