Community Health Center CHC

107 Commercial Street Mashpee MA 02649
Phone: (508) 477-7090 Fax: (508) 477-7028
REQUEST FOR AND RELEASE OF PROTECTED HEALTH INFORMATION

Patient Last Name: _____ **First Name:** _____ **Middle Initial:** ____ **D.O.B.:** _____

Mailing Address: _____

Home phone #:_____ **Work phone #:**_____ **Cell phone #:**_____

I authorize CHC of Cape Cod to

❑RELEASE/DISCUSS (SEND) ❑REQUEST (OBTAIN) *CHECK BOTH FOR SHARING INFO

Information pertaining to my identity, prognosis, diagnosis or treatment.

Information to be released:

❑ My entire record ❑Other:_____

❑Only those portions pertaining to: __Medical history and physical exam __Current medications, lab results and medical diagnoses
__Other (please specify)_____

Name/Facility: _____

Street:_____ City:_____ State:_____ Zip:_____

Phone _____ Fax _____

Under Massachusetts state law we cannot release certain information unless you give us special permission to release it.
By initialing each item I agree to its release:
___Abortion ___HIV/AIDS information** ___Domestic/Sexual abuse ___Mental Health ___Alcohol or Substance abuse*___Sexually Transmitted Diseases (STD)

This authorization is valid for release of Protected Health Information for 180 days from date below **OR (**please indicate):
❑ a one-time disclosure ❑ upon termination from services ❑ until revoked ❑ other_____

*Note: release of information must comply with the federal HIPAA Privacy Act *and* federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations.
** Note: must obtain authorization for *each* requested release of results of HIV/AIDS information.
Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that by law, I do not need to consent to the release of/request for this information to receive care or payment for care or to be eligible for enrollment or any benefits. However, I choose to do so willingly and voluntarily for the purpose specified above. My signature acknowledges my receipt and understanding of CHC of Cape Cod Notice of Privacy Practices. I understand that I have the right to request a copy of my records as provided by CFR 164.524. I understand that I have a right to receive a copy of this form after I have signed it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Supervisor.

Please mail or fax information to:

107 Commercial Street, Mashpee, MA 02649 Fax: (508) 477-7028

I understand that I may revoke this authorization in writing. Upon revocation, information will not be released except to the extent that we have already taken action in response to this authorization.
I also release Community Health Center of Cape Cod from all legal responsibilities and liabilities that may arise from the release of the information.

Signature of patient/personal representative _____ **Date** _____

If signed by anyone other than patient, state relationship and/or reason and legal authority to do so:
Patient is: ❑minor ❑incompetent ❑deceased ❑Parent/legal guardian ❑Legal authority (proof attached)

Signature of witness _____ **Date** _____

A facsimile or copy of this document is as valid as the original