Community Health Center CHC

REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION

107 Commercial Street, Mashpee MA 02649
Phone (508) 477-7090 Fax (508) 539-6063

Patient Last Name:	Patient First Name:	Middle Initial:	Date of Birth:

Patient Mailing Address:	Patient Phone:

I authorize CHC to (check one of the following, or both for bidirectional sharing of info)**:**

❑ **Send my CHC medical records to the following person/facility**

❑ **Request my medical records from the following provider/facility**

Name/Facility:	Phone:	Fax:

Street:	City:	State:	Zip

Medical records include information pertaining to my identity, prognosis, diagnosis, or treatment
Information to be released:

❑ My Entire Record ❑ Other: _____

_____

RELEASE OF SENSITIVE INFORMATION – Please initial to ensure your complete records are released

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:

___HIV/AIDS information (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST WITH SPECIFIC DATES)
___Details of Domestic Violence Victims' Counseling
___Details of Sexual Assault Counseling
___Details of Mental Health Diagnosis and/or treatment provided by a Mental Health Provider (I understand that my permission may not be required to release my mental health records for payment purposes)
___Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon written request

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_____

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's 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 Health Information Manager.

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, print name and select relationship and/or reason and legal authority to do so

Name:_____

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