



Authorization for Release of Protected or Privileged Health Information

- RELEASE COPIES OF HEALTH/MEDICAL RECORD
REVIEW HEALTH/MEDICAL RECORD

Form with fields: Patient Name (Please Print), Patient Date of Birth, Patient Medical Record #, Patient Address (Street {apt #}, City, State ZIP), Patient Telephone Contact #'s

I, \_\_\_\_\_,
Patient Name
do hereby authorize \_\_\_\_\_ to release my protected health information including copies of my medical record of care received at your facility to the following person(s) at the locations/facilities listed below, for the purposes described:

Table with 2 columns: Person(s)/Facility/Address (include Name and Address), Purpose\* (check appropriate box). Includes checkboxes for Medical Care, Insurance\*, Legal Matter\*, Personal\*, School, Other\* (please specify).

Information to be Released (please check all that apply and specify dates)

Form with checkboxes for: Clinic Visit Notes, Pathology Reports, Operative Reports, Radiation Reports, Discharge Summary, Lab Reports, X-rays/Scan Reports, Photographs\*, Medical Record Abstract, Other (please specify). Includes Date: fields.

\* Please refer to the Anna Jaques Hospital Privacy Notice for information on copying fees that may be associated with this request (there may be additional charges for copies of photographs)

# Release of Specifically Protected or Privileged Health Information

**I request the release of the specific categories of information that I have *INITIALED* below:**

- \_\_\_\_\_ HIV test results (Patient Authorization for EACH Release Request) Specify Date(s) \_\_\_\_\_
- \_\_\_\_\_ Genetic test results (excludes therapeutic genetic tests) Specify type of test \_\_\_\_\_
- \_\_\_\_\_ 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 or written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2)*
- \_\_\_\_\_ Other(s) Specify: \_\_\_\_\_

**Confidential Details of:**

- \_\_\_\_\_ Psychotherapy (from a Psychiatrist, Psychologist or Mental Health Clinical Nurse Specialist)
- \_\_\_\_\_ Social Work Counseling/Therapy
- \_\_\_\_\_ Domestic Violence Victims Counseling
- \_\_\_\_\_ Sexual Assault Counseling

I understand that:

I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management at Anna Jaques Hospital or the Office Manager in my physician's office. Authorization may be withdrawn except for the following:

- To the extent that action has been taken in reliance on this authorization
- If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected.

Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Anna Jaques Hospital.

I understand that this authorization will automatically expire (*please check one*):

- In 6 months
- Upon a specific event (specify event) \_\_\_\_\_

I have carefully read and understand the above, have had any questions explained to my satisfaction and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

\_\_\_\_\_ *Signature of Patient* \_\_\_\_\_ *Date*

\_\_\_\_\_ *Print Name*

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian or other legal representative is required.

\_\_\_\_\_ *Signature of Legal Representative* \_\_\_\_\_ *Date*

\_\_\_\_\_ *Print Name* \_\_\_\_\_ *Relationship to Patient*

**FOR INTERNAL USE ONLY**

Information Released/Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic/Office: \_\_\_\_\_