South Boston Community Health Center
409 West Broadway, South Boston, MA 02127
Medical Record Department
Telephone (617) 464-7543 | Fax (617) 464-7680

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient: First Name_____ Last Name_____ Date of Birth_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: _____ (Home) (Cell) (Work) || Email:_____ @_____

I hereby authorize SBCHC to:

❒ **RELEASE/DISCUSS (SEND)** ❒ **REQUEST (OBTAIN) from another facility** (★CHECK BOTH FOR SHARING INFO)

Information to be released or obtained pertaining to my identity, prognosis, diagnosis or treatment.

❒ Complete Record ❒ Last Physical ❒ Immunization Records ❒ Medication List
❒ Lab Results _____ ❒ X-rays Imaging Reports_____ ❒ Dental Records Only ❒ Eye Records Only ❒ GYN/Prenatal Records
❒ Medical Record Abstract (Recent Office Visit or Physical, Labs, x-rays, Immunizations)_____ ❒ Other (specify)_____

PURPOSE for information (CHECK APPROPRIATE BOX)

❒ Legal* ❒ Insurance* ❒ Personal* ❒ School ❒ Medical Care ❒ Other (please specify)*_____
(See NPP) *Reasonable copying fees may be associated with this request ** There may be additional charges for copies of films or photographs

Name/Facility:_____

Address: _____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Release this information in electronic format:

ENCRYPTED: ❒email ❒ CD ❒ USB Flash drive **UN-ENCRYPTED**: ❒email ❒USB flash drive ❒ specify electronic method

By Massachusetts and Federal Law we cannot release certain information unless you give us permission by checking the appropriate box:

❒**Yes** ❒ **No** Abortion
❒**Yes** ❒ **No** Sexual Assault
❒**Yes** ❒ **No** Claims/Billing Info
❒**Yes** ❒ **No** Sexually Transmitted Diseases
❒**Yes** ❒ **No** Physical or Sexual Abuse
❒**Yes** ❒ **No** AIDS/HIV info or test result (pt. authorization required for each request)
❒**Yes** ❒ **No** Mental Health Visits
❒**Yes** ❒ **No** Genetic Testing
❒**Yes** ❒ **No** Infertility Studies
❒**Yes** ❒ **No** Developmental Disability
❒**Yes** ❒ **No** Drug and/or Alcohol Abuse or Test results (Protected by Federal confidentiality Rules 42CFR.Part2 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 42CFR.P.2) Do not re-disclose unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

I UNDERSTAND: ❒ I may revoke this authorization at any time by providing the medical record department with a written revocation, and that the revocation will be honored with the exception • to the extent that this authorization has been acted upon or • if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest acclaim under the policy. ❒ That this information may be redisclosed by the recipient if the recipient is not required to follow the privacy regulations or statutes. ❒ That I am under no obligation to sign this and that the recipients who I am authorizing to use and/or disclose my information to may not condition treatment, payment, and enrollment in a health plan or other fees associated with this request. ❒ That this authorization will automatically expire in 6 months.

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 / legal or personal representative **PRINT** Patient name **PRINT** Relationship to patient **DATE**

WHEN PATIENT IS A MINOR, OR IS NOT COMPETENT TO GIVE CONSENT, THE SIGNATURE OF A PARENT, GUARDIAN OR OTHER LEGAL REPRESENTATIVE IS REQUIRED. CHECK APPROPRIATE BOX: ❒**MINOR** ❒**INCOMPETENT** ❒**DECEASED** ❒**PARENT/LEGAL GUARDIAN** ❒**LEGAL AUTHORITY**

For Internal Use Only
Request or Pick-Up Identification type ❒License ❒State ID ❒Passport ❒Other Photo ID Person verifying _____
*Notice of Retention of Records: In accordance with M.G. L. 111 § 70, SBCHC will maintain medical records for a minimum of 20 years after the final treatment.
Revised June 2016
A faxed copy of this document is as valid as the original