

UMASS MEMORIAL HEALTH
**AUTHORIZATION FOR THE DISCLOSURE
 OF PROTECTED HEALTH INFORMATION**

Page 1 of 2

PLEASE SELECT ALL ENTITIES THAT APPLY

- | | | |
|---|--|--|
| <input type="checkbox"/> Community Healthlink | <input type="checkbox"/> HealthAlliance-Clinton Hospital | <input type="checkbox"/> Milford Regional Medical |
| <input type="checkbox"/> UMass Memorial Medical Center | <input type="checkbox"/> Harrington Hospital | <input type="checkbox"/> Milford Regional Provider Group / |
| <input type="checkbox"/> UMass Memorial Medical Group / | <input type="checkbox"/> Harrington Physicians / | Location: _____ |
| Location: _____ | 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 AT LEAST ONE):

- Check here to release records to self.
- Release** information from the medical record of the above named patient to the recipient specified below.
- Request & Receive** information from the organization, department, or individual specified below.
- Check here to release records to patient's address above or provide a different address below:

Name: _____
 Street Address: _____ P.O. Box / Apt. # / Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Disability/Insurance Application/Claim | <input type="checkbox"/> Personal Use | <input type="checkbox"/> Attorney/Legal Case | <input type="checkbox"/> Continuous Care |
| <input type="checkbox"/> OTHER (specify): _____ | | <input type="checkbox"/> Pre-employment | <input type="checkbox"/> Verbal Communications |

PLEASE COMPLETE THE INFORMATION BELOW (Choose One):

Individual Visit(s).

Date(s) From: _____ Through: _____

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

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: _____

- | | |
|---|---|
| <input type="checkbox"/> Consultations | <input type="checkbox"/> Pathology Report(s) |
| <input type="checkbox"/> Discharge Summaries | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Emergency Service Records | <input type="checkbox"/> Radiology Images |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Rehabilitation: Physical Therapy, Occupational Therapy, Speech Therapy |
| <input type="checkbox"/> Laboratory Reports (blood tests) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Office/Clinic Notes for _____ | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Operative/Procedure Report(s) | <input type="checkbox"/> 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.**

- | | | |
|--|---|--|
| <input type="checkbox"/> Abortion - Consent Forms or Court Orders | <input type="checkbox"/> Genetic Screening Test Results | <input type="checkbox"/> Sexual Assault Counseling |
| <input type="checkbox"/> Domestic Violence Counseling | <input type="checkbox"/> HIV/AIDS Test Results | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Communication of Mental Health Diagnosis and/or Treatment Provided by a Psychologist, Psychiatrist, Mental Health Clinical Nurse Practitioner, Licensed Mental Health Counselor, and Licensed Social Worker | | |
| <input type="checkbox"/> The Treatment of Alcohol/Substance Use Disorder | | |

