



Authorization for the Release of Protected Health Information

Patient Name: _____ CSHC MR # _____
Telephone: _____ Date of Birth _____
Address: _____

I authorize Codman Square Health Center or _____ to release my
(name of facility releasing record)

Protected Health Information (PHI), including copies of my medical record to:

- Codman Square Health Center or Patient (Self)
Name and Address of Person(s) or facility receiving information
Mail Pick-up (ID required) Other

Purpose of Request (please check appropriate box):

- Medical Treatment Insurance/Worker's Comp Legal Matter Personal Other

Include treatment dates from _____ to _____

Information to be released (please check all that apply):

- Immunization Record X-ray reports EKG tracings Last Physical Medical Progress Notes
Laboratory results Itemized Bill Dental Records Other (please specify)

I understand that my record may contain some highly confidential information.

By initialing the lines below, I am specifically authorizing its release:

Genetic Testing Abortion Mental health/Psychiatric Treatment
Sexual Abuse, Physical Abuse, Domestic Violence Substance Abuse

I understand that my drug treatment records are protected under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Records 42 CFR Part 2.

Sexually transmitted diseases HIV Testing/Treatment

I understand that my STD records are protected under state law Chapter 111, section 119 which states that my STD records shall not be disclosed except upon proper order by a judge to a person whose job, in the opinion of the Commissioner of Public Health, entitles him or her to receive the information.

I understand that I can withdraw my authorization for release of my PHI information at anytime by indicating in writing to the Medical Records Manager, as long as action has not already been taken in releasing it.

I understand that the PHI requested via this authorization may be released by the recipient/receiver to another party and may no longer be protected by the privacy rules.

I understand that if I refuse to sign this form I will not be refused treatment and my payment, health plan enrollment or eligibility will not be affected.

I have carefully read and understand the above and am therefore authorizing disclosure of my protected information to the person or agency indicated above.

This authorization is good for One year from date of signature or until date indicated below

Please Print Requesters Name Here: _____
Signature: (Legal Guardian if patient is minor or unable to sign) _____ Date: _____
Witness: _____ Date: _____

Limited expiration date for this authorization is ____/____/____

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Contact Information: Codman Square Health Center, Medical Records Department, 637 Washington St. Dorchester, MA 02124
Phone: 617-822-8253 Fax; 617-825-3663

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