Codman Square
Health Center

637 Washington St. Dorchester MA, 02124 | 617-825-9660 | codman.org
Health Information Department Telephone: 617-822-8253 | Fax: 617-825-3663

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

I hereby authorize Codman Square Health Center to:
☐ **Obtain from:** ☐ **Release to:** ☐ **Verbally speak with:**

Name/Entity: _____ **Tel #:** _____
Title: _____ **Fax #:** _____
Facility: _____ **Treatment Dates: From**_____ **To**_____
Address: _____

Please initial the following information: ** *Psychotherapy notes or Substance Abuse Treatment requests cannot be combined with other request for release of records. This request requires a separate and independent Authorization Form.*

___ **Lab Results**
___ **General Information**
___ **HEP C**
___ **X-Ray Reports**
___ **Sexual/Physical Abuse**
___ **Mental Health/Psychiatric Treatment**
___ **Domestic Violence**
___ **Abortion**
___ **Substance Abuse *(Specifically describe below in detail the records to be disclosed)***
___ **EKG Tracings**
___ **Dental Records**
___ **Immunization/PE Form**
___ **Other**:_____

___ **Family Planning** *(Family Planning information will be released to patient on patient's authorization or with a court order. Patient's parents/guardian will not be granted access even if a patient is a minor)*

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

___ **HIV/AIDS** *(I specifically give permission, under M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment)*

Intake/Discharge Summary ☐ Medications ☐ Toxicological Results ☐ Progress Notes ☐ Treatment Verification Letters ☐

No documentation, only verbal ☐ Other (please describe):_____

The purpose of disclosure authorized herein is specifically for:
Medical Treatment___ **Workmen's Comp**___ **Legal Matter**___ **Disability/Social Security**___ **Transfer of Care**___ **Other**_____

☐ **Mail** ☐ **Pick Up (ID Required)** ☐ **Email** (for personal use only. You may not re-release electronically to anyone else. No sensitive information will be released electronically. You will need to read and sign the accompanying form consenting to the electronic release of your information.)

Date of Expiration: _____ (this authorization is good for one year from date of signature or until indicated)

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. **A general authorization** for the release of medical or other information is **not sufficient** for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that I have a right to receive a list of entities to which my Part 2 information (Substance Abuse Records) has been disclosed pursuant to any "general designation".· A request for a list of disclosures must be in writing (either electronic or paper documentation).

I understand that I can withdraw my authorization for release of my PHI at any time by indicating in writing to the Health Information Services Manager, except to the extent that the program or person which is to make the disclosure has already acted in reliance on it.

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.

_____ _____
Patient's Signature (or Legal Guardian if patient is a minor) **Date** **Witness's Signature** **Date**

_____
Requestor's Name **Date**

A copy of this authorization shall be considered as valid as the original. Please be aware there may be a fee for copies of health information. 04/2017