Codman Square Health Center
637 Washington St., Dorchester, MA 02124
617-822-8253 • codman.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION*

**FOR BOARD MEMBERS WHO ARE ALSO PATIENTS OF CODMAN SQUARE HEALTH CENTER*

Patient Name: ______________________ **Date of Birth:** ______________

Address: ______________________ **Telephone:** ______________

______________________ **CSHC MR#:** ______________

I hereby authorize Codman Square Health Center or ______________________ **to release my Protected Health Information (PHI), including copies of my medical record to:**

Name/Entity: *Codman Square Health Center* **Tel #:** *617-822-8172*

Title: *Compliance Director* **Fax #:** *617-825-3663*

Facility: *Codman Square Health Center* **Treatment Dates:** From ________ To ________

Address: *637 Washington St., Dorchester, MA 02124*

The purpose of disclosure authorized herein is specifically for: ☐ Medical Treatment ☐ Workmen's Comp ☐ Legal Matter ☐ Disability/Social Security ☐ Transfer of Care ☑ Other *HRSA Compliance FQHC 330 Rules*

Delivery of Protected Health Information: ☐ Mail ☐ Pick Up *(ID Required)* ☐ Email *(For personal use only. You may not re-release PHI 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.)*

Information to be released *(Check all that apply)*:

☐ **Immunization/PE Form** ☐ **X-Ray Reports** ☐ **EKG Tracings**

☐ **Last Physical** ☐ **Medical Progress Notes** ☐ **Lab Results**

☐ **Itemized Bill** ☐ **Dental Records** ☑ **Other:** *Appointment Dates*

I understand that my record may contain some highly confidential information. By initialing below, I am specifically authorizing its release.
*** 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.*

INITIAL **Genetic Testing** INITIAL **Abortion** INITIAL **Mental Health/Psychiatric Treatment**

INITIAL **Sexual/Physical Abuse** INITIAL **Domestic Violence**

INITIAL **Substance Abuse** *(Please describe the type of records to be disclosed):* ______________________
(I understand that my drug treatment records are protected under federal regulation governing Confidentiality of Alcohol and Drug Abuse Records 42 CPR Part 2)

INITIAL **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)*

INITIAL **STD** *(I understand 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.)*

INITIAL **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)*

Date of Expiration: *This authorization is good for the duration of the requester's Board tenure*

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 Signature *(Legal Guardian if patient is a minor)*	**Witness Signature**	**Requestor's Name** *(Please print)*
______________________	______________________	______________________
Date	**Date**	**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.