X FOR BOARD MEMBERS WHO ARE ALSO PATIENTS OF CSHC

Authorization for the Release of Protected Health Information

Codman Square
Health Center

Patient Name: _____ CSHC MR # _____

Telephone: _____ Date of Birth _____

Address: _____

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

☒ Codman Square Health Center or ☐ Name & Address of Persons or _____

☐ Patient (Self) Compliance Director 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 HRSA Compliance FQHC 330 Rules

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) Appointment dates

_____

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 *(use BH form)*

_____ Sexual Abuse, Physical Abuse, Domestic Violence _____ Substance Abuse _____Family Panning
(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 patient is a minor)

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

_____ Sexually Transmitted Diseases _____ HIV Testing/Treatment

I understand that my STD records are protected under state law **Chapter111, 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 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 indicated below
Limited expiration date for this authorization is X/ ___/ _____ *Duration of Board tenure

→ **Please print Requester's Name here:** _____

→ **Signature:** ***(Legal Guardian if patient is a minor or unable to sign)*** _____ **Date:** _____

Witness: _____ **Date:** _____

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