Heywood Healthcare
Athol Hospital | Heywood Hospital

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

MRN # _____ Email _____

Patient Name: _____ DOB: _____ Phone: _____

Address: _____
Street City State Zip

I Authorize HHH/Athol to: ☐ **Release** my Medical Record to: ☐ **Obtain** my Medical Record from:

Name and address of Facility/Organization/Company/Person to release/obtain this information:

_____
Facility/Organization/Company/Person Phone Fax

_____
Address Street City State Zip

The Purpose for this Release of Information is:

☐ Personal Use ☐ Attorney/Legal ☐ Disability ☐ Insurance ☐ Employment ☐ Worker's Compensation

☐ Other: _____

Specific Information to be Released :(subject to copy fees allowed by the state of MA) ☐ entire medical record

☐ Health Record (Date(s) of Service) from: _____ to: _____

☐ Discharge summary, ☐ Operative reports, ☐ X ray reports, ☐ Rehab Notes, ☐ EMG/ EKG/ Tracing./report,

☐ Last History and Physical, ☐ Prenatal/OB Record, ☐ Abstract, ☐ Clinic records, ☐ Surgical reports

☐ Medication List, ☐ Laboratory Results, ☐ Consultation Report's, ☐ Diagnostic Imaging Reports

☐ Cardio/Pulmonary reports, ☐ Emergency Room Records, ☐Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company the law provides my insurer with the right to access my information under my policy.

Unless otherwise revoked**, this authorization is valid for 90 days after the date signed unless canceled in writing.** Please indicate an expiration date beyond 90 days or state ☐indefinitely **(Expiration date)** _____. I understand that authorizing the disclosure of this health information is voluntary I need not sign this form in order to assure treatment. I may receive a copy of this form.

Information that you authorize to be disclosed may be subject to re-disclosure and no longer protected by law to the extent applicable. I understand that my record may contain information that is considered sensitive under the law. PHI cannot be used or disclosed unless you specifically authorize such use or disclosure under 42-CFR Part 2 of the federal confidentiality regulations. This information shall not be transmitted without specific authorization as provided in these regulations.

My initials below indicate that I permit the following information, if applicable in my health record, to be released:

_____ HIV/AIDS-Related Information, including status, results, treatments, diagnoses and/or referrals

_____ Drug and Alcohol Abuse Information, including status, results, treatments, diagnoses and/or referrals

_____ Behavioral Health Information, including status, results, treatments, diagnoses and/or referrals

_____ Communicable Diseases, including status, results, treatments, diagnoses and/or referrals

_____ _____ _____ _____
Signature of Patient or Legal Representative Date Signature of Witness (if signed by legal representative) Date

OFFICE USE ONLY: ID Verified: ☐ Yes ☐ No Date Released: _____Fee Collected: ☐ Yes ☐ No AMT: _____

Legal Representative documentation provided: ☐ Yes ☐ No specify;_____ Initials, HIM Staff: _____