



South Boston Community Health Center
 409 West Broadway, South Boston, MA 02127
 Medical Record Department
 Telephone (617) 464-7543 | Fax (617) 464-7680

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient: First Name _____ Last Name _____ Date of Birth _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ (Home/cell) _____ (Work) || Email: _____ @ _____

I hereby authorize SBCHC to:

- RELEASE/DISCUSS (SEND)** **REQUEST (OBTAIN) from another facility** (★CHECK BOTH FOR SHARING INFO)

Information to be released or obtained pertaining to my identity, prognosis, diagnosis or treatment.

- Complete Record Last Physical Immunization Records Medication List
 Lab Results _____ X-rays Imaging Reports _____ Dental Records Only Eye Records Only GYN/Prenatal Records
 Medical Record Abstract (Recent Office Visit or Physical, Labs, x-rays, Immunizations) _____ Other (specify) _____

PURPOSE for information (CHECK APPROPRIATE BOX)

- Legal* Insurance* Personal* School Medical Care Other (please specify)* _____
 (See NPP) *Reasonable copying fees may be associated with this request ** There may be additional charges for copies of films or photographs

Request From or Send To:
 Name/Facility: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Fax: _____
 Release this information in electronic format:
 RETRIEVE RECORDS ELECTRONICALLY FROM EPIC ELECTRONIC HEALTH RECORD
ENCRYPTED: email CD USB Flash drive **UN-ENCRYPTED:** email USB flash drive specify electronic method



By Massachusetts and Federal Law we cannot release or obtain certain information unless you give us permission by checking the appropriate box:

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Abortion | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS/HIV info or test result (pt. authorization required for each request) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sexual Assault | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Health Visits |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Claims/Billing Info | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genetic Testing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually Transmitted Diseases | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infertility Studies |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Physical or Sexual Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Developmental Disability |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Drug and/or Alcohol Abuse or Test results (Protected by Federal confidentiality Rules 42CFR.Part2 prohibit any further disclosure of this information unless further disclosure is expressly permitted or written consent of the person to whom it pertains or as otherwise permitted by 42CFR.P.2) Do not re-disclose unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. | | |

I UNDERSTAND: I may revoke this authorization at any time by providing the medical record department with a written revocation, and that the revocation will be honored with the exception • to the extent that this authorization has been acted upon or • if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest acclain under the policy. That this information may be redisclosed by the recipient if the recipient is not required to follow the privacy regulations or statutes. That I am under no obligation to sign this and that the recipients who I am authorizing to use and/or disclose my information to may not condition treatment, payment, and enrollment in a health plan or other fees associated with this request. That this authorization will *automatically expire in 6 months*.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

Signature of patient / legal or personal representative **PRINT** name **PRINT** Relationship to patient **DATE**
 WHEN PATIENT IS A MINOR, OR IS NOT COMPETENT TO GIVE CONSENT, THE SIGNATURE OF A PARENT, GUARDIAN OR OTHER LEGAL REPRESENTATIVE IS REQUIRED.
 CHECK APPROPRIATE BOX: MINOR INCOMPETENT DECEASED PARENT/LEGAL GUARDIAN LEGAL AUTHORITY

For Internal Use Only
 Request or Pick-Up Identification type License State ID Passport Other Photo ID Person verifying _____
 *Notice of Retention of Records: In accordance with M.G. L. 111 § 70, SBCHC will maintain medical records for a minimum of 20 years after the final treatment.
 Revised June 2016
 A faxed copy of this document is as valid as the original