UMASS MEMORIAL MEDICAL CENTER

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT TO COMPLETE THIS SECTION:

FULL NAME:

ADDRESS:

BIRTHDATE/AGE: SEX:

MEDICAL RECORD NUMBER:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

☐ Check if you want UMass Memorial Medical Center to release the medical records for this patient to someone you specify below:
☐ Check if you want UMass Memorial Medical Center to receive this patient's medical records from another health care provider.

Name: ______________________________ Telephone: ______________________

Address:____

A. Email Address:______________________________

Would you like to receive this information electronically? ☐ Yes ☐ No

I understand that my health record may include general information related to my mental health, drug/alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this authorization pertains to information obtained on or before the date this authorization was signed. I authorize the release of the following information for dates of service from **B.** ___________ through **C.** _____________.

D. GENERAL RECORDS

☐ Cardiac Studies-Heart
☐ Consultations
☐ Discharge Summaries
☐ EEG/EMG/Sleep Studies
☐ Emergency Service Records
☐ Immunization Records
☐ Laboratory Reports
☐ Office/Clinic Notes for Dr.__________________
☐ Operative/Procedure Reports
☐ Pathology Reports
☐ Patient Discharge Care Form
☐ Problem List
☐ Pulmonary Studies-Lung/Respiratory
☐ Radiology Reports
☐ Rehabilitation Notes-PT/OT/Speech
☐ **OTHER (specify):** ______________________________

E. PROTECTED UNDER STATE LAW ***(*box must be checked to have information released*)***

☐ Abortion
☐ Alcohol/Drug Abuse
☐ Domestic Violence Counseling
☐ Genetic Testing
☐ HIV/AIDS Results/Treatment
☐ Psychiatric Health-including Psychotherapy notes
☐ Sexual Assault Counseling
☐ Sexually Transmitted Diseases
☐ **OTHER (specify):** ______________________________

F. THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

☐ Appointment with Specialist
☐ Transferring Care to New Provider
☐ Attorney/Legal Case
☐ Disability/Insurance Application/Claim
☐ Personal Use
☐ Pre-employment
☐ **OTHER (specify):** ______________________________

I UNDERSTAND THAT:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I may inspect or copy information to be disclosed as provided in the Joint Notice of Information Practices.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release UMass Memorial Medical Center from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke this authorization at any time by presenting a written request to Health Information Management at the address below. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked this authorization will expire on the following date, event or condition: **G.** ____________________________________. If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

______________________________	____________	____________________
H. Signature of Patient/Parent/Legal Representative*	**I.** Date	**J.** Signer's Relationshp to Patient

______________________________	____________	____________________
K. Witness to Signature	**L.** Date	**M.** For Hospital Use Only - Identification (MA License or Other)

**If signing as a legal representative, also provide appropriate paperwork to support status.*

N. Health Information Management
UMass Memorial Medical Center
55 Lake Avenue North, Worcester, MA 01655
Tel 508-334-5700 opt. 1 Fax 508-334-9721

****A copy of completed authorization must be given to patient.****