UMASS MEMORIAL MEDICAL CENTER

INSTRUCTIONS FOR THE COMPLETION OF THE AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

- If you want UMass Memorial Medical Center to ***release*** this patient's medical records to someone you specify, check the first box.
  - If you checked the first box, please specify the name, address, and telephone number of the person/organization to whom/which you want UMass Memorial Medical Center to send this patient's medical records.

- If you want UMass Memorial Medical Center to ***receive*** this patient's medical records from another health care provider, check the second box.
  - If you checked the second box, please specify the name, address, and telephone number of the health care provider from whom you want UMass Memorial Medical Center to receive this patient's medical records.

A. If you would like to receive this information electronically, select yes and enter a valid email address.

B. Please print the oldest date of service of the records you seek.

C. Please print the most recent date of service of the records you seek.

D. Please check which general medical records you want released or received.

E. Please check which records protected under state law (records that by law require specific authorization for disclosure) you want released or received.

F. Please check the box that specifies the purpose of your request.

G. Please specify a date or event (e.g. "end of treatment," "settlement of case") upon which this authorization will expire.
NOTE: If no expiration is specified, the authorization will automatically expire 90 days from the date signed.

H. The patient or authorized representative must sign the authorization here.

I. Please print the date the authorization is signed.

J. Please specify the relationship of the signer to the patient (e.g. "self," "mother").

K. A witness to the signature of **(H)** should sign here.

L. Please print the date the witness signed the authorization.

M. ***FOR MEDICAL CENTER USE ONLY***

N. Please mail your completed and signed request to this address, **OR** fax your request to the number listed.
NOTE: Please do not do both as it may create duplicate requests and may delay the processing of one or both of the requests.

NOTE: Please retain a copy of your completed and signed request for your records.

THIS IS NOT PART OF THE PERMANENT MEDICAL RECORD.