UMassMemorial
Marlborough Hospital

Authorization for the Disclosure of Protected Health Information

Please Print

Name: _____ **DOB:** _____ Telephone # _____

I, hereby, authorize **Marlborough Hospital**, a member of UMass Memorial Health Care, Inc. to ☐ disclose my protected health information to (list below) and/or ☐ obtain my protected health information from: _____ .

Name: _____

Address: _____

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 the period of _____ through _____ .

GENERAL RECORDS

- ☐ Cardiac Studies (Heart)
- ☐ Consultations
- ☐ Discharge Summaries
- ☐ EEG/EMG/Sleep Studies
- ☐ Emergency Service Records
- ☐ Immunization Records
- ☐ Laboratory Testing
- ☐ Operative/Procedure Reports
- ☐ Pathology Reports
- ☐ Radiology Reports
- ☐ Rehabilitation Notes
- ☐ Medications / Medication Providers
- ☐ Problem List
- ☐ Aftercare Plan
- ☐ Diagnostic Imaging

OTHER (specify) _____

STATUTORILY PROTECTED RECORDS

- ☐ Abortion
- ☐ Alcohol/Drug Abuse
- ☐ Sexual Assault Counseling
- ☐ Psychiatric Heath including Psychotherapy
- ☐ Domestic Violence Counseling
- ☐ Genetic Testing
- ☐ HIV/AIDS Results/Treatment
- ☐ Sexually Transmitted Diseases

OTHER (specify) _____

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

- ☐ Continuing Medical Care
- ☐ Transferring Care
- ☐ 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 Notice of Information.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release Marlborough Hospital 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 the Medical Records Department 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: _____. 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.

Signature of Patient/Parent/Legal Representative*	Time	Date	Relationship to Patient
Witness to Signature	Time	Date	For Hospital Use Only

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

PLEASE MAIL YOUR REQUEST TO: **Medical Records Department**
Marlborough Hospital
157 Union Street, Marlborough, MA 01752

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

Reorder #51060

10/15