

UMASS MEMORIAL HEALTH CARE

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

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PATIENT TO COMPLETE THIS SECTION:

FULL NAME:

ADDRESS:

BIRTHDATE/AGE:

SEX:

HAR/CSN:

- UMass Memorial Medical Center
UMass Memorial HealthAlliance-Clinton Hospital
UMass Memorial - Marlborough Hospital
UMass Memorial Medical Group - Location:

PRINT CLEARLY IN INK OR IMPRINT WITH PATIENT'S CARD

I hereby authorize the entity selected above, its employees, and/or agents, to (SELECT ONE):

- Request & Receive information from the health care provider/organization specified below.
Release information from the medical record of the above names patient to the recipient specified below.

- Self (see above)
Health Care Provider (no charge if sent directly to physician's office)
Organization/Person/Other (Insurance co., lawyer, etc.)

Name:
Street Address: P.O. Box / Suite#:
City: State: Zip Code:
Phone: Fax: Email:

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

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

COPY FEE: Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. At no time will the cost-based fees exceed Massachusetts law (MGL Chapter 111; Section 70).

Directions: Please select ONE of the three options below by checking the appropriate box.

1. Individual Visit(s). Please check either Abstract or Entire Visit Date box.

- Abstract of Visit Date. Includes key elements of a specific visit date(s) including: reports, diagnostic testing (labs, x-rays, EKGs, PFTs, medication reconciliation list, allergies and provider's transcribed reports). An abstract contains the most commonly requested information and is less expensive.
Entire Visit Date. Includes any and all documentation related to a specific visit date(s).

Date(s) From: Through:

2. Specific Services. If you wish to receive ONLY copies of specific service(s), please check ONLY the report type(s) that you are requesting and provide the date/range (when the services occurred) on the line below.

Date(s) From: Through:

- Cardiac Studies-Heart
Consultations
Discharge Summaries
Neurological tests: EEG, EMG, Sleep Study
Emergency Service Records
Immunization Records
Laboratory Reports (blood tests)
Office/Clinic Notes for Dr.
Operative/Procedure Report(s)
Pathology Report(s)
Patient Discharge Care Form(s)
Pulmonary Studies: (Lung) Pulmonary Function Tests
Radiology Reports
Rehabilitation: Physical Therapy, Occupational Therapy, Speech Therapy
Other (specify):
Other (specify):

3. Entire Medical Record. Please check EITHER the Abstract or Entire Medical Record box below.

Note: The Abstract and/or Entire Medical Record could both include more than twenty (20) years of records from the date of your last visit.

- Abstract of Entire Medical Record. Includes key elements of a specific visit date(s) including: reports, diagnostic testing (labs, x-rays, EKGs, PFTs, medication reconciliation list, allergies and provider's transcribed reports). An abstract contains the most commonly requested information and is less expensive.
Entire Medical Record. Includes any and all documentation of a patient's entire medical record. Please note that selecting this option may result in a significant cost to prepare the records.

PROTECTED UNDER STATE OR FEDERAL LAW

I understand that my health record may include information related to my mental health, alcohol/substance use disorder, sexual assault, sexually transmitted diseases, abortion, genetic testing, HIV/AIDS, domestic violence, or other information I may consider sensitive. You must initial next to the types of content below or that information will NOT be released.

- Abortion - Consent Forms or Court Orders
Domestic Violence Counseling
Details of Mental Health Diagnosis and/or Treatment Provided by a Psychologist, Psychiatrist, Mental Health Clinical Nurse Practitioner, Licensed Mental Health Counselor, and Licensed Social Worker
Alcohol/Substance Use Disorder; must specify exact nature of information needed:
Genetic Screening Test Results
HIV/AIDS Test Results
Sexual Assault Counseling
Sexually Transmitted Diseases
OTHER (specify):

Please Continue on Reverse Side



