

**UMASS MEMORIAL HEALTH CARE
AUTHORIZATION FOR THE
DISCLOSURE OF PROTECTED
HEALTH INFORMATION**
Page 1 of 2

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Appointment with Specialist | <input type="checkbox"/> Attorney/Legal Case | <input type="checkbox"/> Verbal Communications |
| <input type="checkbox"/> Transferring Care to New Provider | <input type="checkbox"/> Disability/Insurance Application/Claim | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Caregiver | <input type="checkbox"/> OTHER (specify): _____ | <input type="checkbox"/> 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: _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Abortion - Consent Forms or Court Orders | <input type="checkbox"/> Genetic Screening Test Results | <input type="checkbox"/> Sexual Assault Counseling |
| <input type="checkbox"/> Domestic Violence Counseling | <input type="checkbox"/> HIV/AIDS Test Results | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> 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 | | |
| <input type="checkbox"/> Alcohol/Substance Use Disorder; must specify exact nature of information needed: _____ | | |

OTHER (specify): _____

Please Continue on Reverse Side



