



MATTAPAN COMMUNITY HEALTH CENTER

1575 Blue Hill Avenue, Mattapan, MA 02126 | ph. 617-296-0061 | fax. 617-296-5408 | www.mattapanchc.org

GENERAL RECORDS RELEASE / AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Step 1 - Patient Name: _____

DOB: _____

By signing this General Records Release / Authorization for Use or Disclosure of Protected Health Information ("Authorization"), I hereby authorize _____, to release my protected health information ("PHI") as specified herein to the following persons / entities ("Recipient"):

Person(s) / Facility

Address / Contact Information

Step 2 - Request Details

Reason for request: ☐ At my request (only patient can check this box).
☐ For my health care
☐ For payment/insurance
☐ For legal matter
☐ For employment purposes
☐ Other (please specify): _____

Date Range of Services: From ___ / ___ / ___ to ___ / ___ / ___ or ☐ **All** Medical Records

Please indicate the **specific categories of information** you agree to release by checking and initialing the boxes below:

- | | |
|---|---|
| ☐ _____ HIV/AIDS (specify dates _____) | ☐ _____ Sexual Assault |
| ☐ _____ Sexually transmitted diseases | ☐ _____ Behavioral Health (Initial intake, most recent treatment plan/ |
| ☐ _____ Domestic Violence treatment/counseling discharge/transfer summary) | |
| ☐ _____ Family planning services | ☐ _____ Psychotherapy notes |
| ☐ _____ Alcohol or Drug Abuse (protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION IN THIS RECORD UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WITH WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2) | |



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☐ _____ Other(s): _____ (please specify)

Step 3 - Authorization Terms and Signatures:

I understand and agree that:

1. With my signature the information specified above will be released to the Recipient designated above.
2. The Authorization is valid for 1 year unless I indicate a different time or reason for expiration.
3. Once the information has been released, MCHC cannot guarantee that the Recipient will not re-disclose the information to another party who may not be required to comply with state and/or federal laws governing the use and disclosure of PHI and, in such case, the PHI described above may be re-disclosed and would no longer be protected by such laws governing privacy of health information.
4. I may revoke this Authorization at any time except to the extent that MCHC has taken action in reliance on this Authorization. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at the address above.
5. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from MCHC, except when: (i) my refusal may limit MCHC's ability to provide safe and effective care; (ii) I am receiving research-related treatment; or (iii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these exceptions apply, my refusal to sign an authorization may result in my not obtaining treatment from MCHC.
6. I may be expected to pay a small fee to cover the costs of releasing the information as authorized by law. MCHC has provided me with information on the amount of such fee.

I have carefully read and understand the terms of this Authorization. I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize the disclosure of the above protected health information to the designated person/entity as specified above. I give my permission to share my protected health information, which may include protected or privileged information, in written and/or other stored format.

Patient (or authorized individual) _____ Signature _____

Other name(s) used as a patient: _____ Telephone: (____)____ - _____

Address: _____



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Street	Apt. #	City	State	Zip Code
Date ____/____/____				
If not patient – indicate relationship below:				
☐ When patient is under legal age or incompetent to give consent, signature of parent, legal guardian, health care agent (proxy) is required. In such cases, identity and documentation of legal authority must be confirmed. (Note: Executors requesting records must provide a <u>court order</u> establishing estate executorship with <u>Date of Death</u> : ____/____/____)				
Printed Name: _____ Signature _____				
Date _____				
Relationship to Patient: ☐ Legal Guardian ☐ Legal Representative (please specify) _____				

☐ I will pick up the information: At _____				
☐ Please send the information to address below <u>or</u> ☐ via Fax (____) ____-____				
Name _____ Facility _____				

Last	First	Middle		
Address: _____				

Street	Apt #	City	State	
Zip Code _____				
Telephone: (____) ____-____				

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