Authorization for the Disclosure of Protected Health Information

PATIENT NAME:_____DOB_____/_____/_____

☐ Check if you want **Women's Health of Central MA to RELEASE records TO** name specified below:
☐ Check if you want **Women's Health of Central MA to RECEIVE records FROM** another Health Care Provider below:

Where records are **GOING TO *or* COMING FROM**:

Health Provider or other:_____Telephone: _____
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 dates of service from _____ through _____.

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

☐ Appointment w/ Specialist ☐ Attorney/Legal Case ☐ Personal Use
☐ Transferring Care to New Provider ☐ Disability/Insurance Application/Claim ☐ Pre-employment
☐ **OTHER (specify)** _____

Please check all that apply for release authorization:

GENERAL RECORDS

☐ Cardiac/Heart Studies ☐ Immunization Records ☐ Inpatient information
☐ Consultations ☐ Laboratory Reports ☐ Problem List
☐ Discharge Summaries ☐ Office/Clinic Notes for Dr._____ ☐ Pulmonary/Lug Studies
☐ EEG/EMG/Sleep Studies ☐ Operative/Procedure Reports ☐ Radiology/Ultrasound Reports
☐ Emergency Records ☐ Pathology Reports ☐ Rehab Notes-PT/OT/Speech
☐ **OTHER (specify)** _____

STATUTORILY PROTECTED RECORDS

☐ Abortion ☐ Genetic Testing ☐ Sexual Assault Counseling
☐ Alcohol/Drug Abuse ☐ HIV/AIDS Results/Treatment ☐ Sexually Transmitted Diseases
☐ Domestic Violence Counseling ☐ Psychiatric Health/Psychotherapy notes
☐ **OTHER (specify)**_____

I UNDERSTAND: 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 Privacy Notice.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release Women's Health of Central Mass (WHCMA) 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 WHCMA 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 _____.
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* Date Signer's Relationship

_____ _____ _____
Witness to Signature Date For Office Use Only - Identification
*If signing as a legal representative, also provide appropriate paperwork to support representative status. (MA License or Other)

☐**328 Shrewsbury Street, Suite 100, Worcester, MA 01608** ☐**325 Thompson Road, Webster, MA 01570**
☐**320 Bolton Street, Ground Level, Marlboro, MA 01752** ☐**118 Main Street, Sturbridge, MA 01566**

PHONE: (508) 755-4861 | ***FAX:*** *(508) 752-1392* | **WEBSITE:** www.whcma.com | **EMAIL**: info@whcma.com

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