Charles River Community Health ("Health Center")

495 Western Avenue, Brighton, MA 02135 – Phone (617) 208-1575 - Fax (617) 870-7346

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

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

Patient's Information

Patient's Name _____ Patient's Date of Birth: _____ / _____ / _____

Last First Middle

Other name(s) used as a patient here: _____

Telephone: (_____) _____ - _____ Email: _____

Address: _____City_____State_____Zip_____

Reason for Request:

❑ Personal use ❑ Transfer of care ❑ Referral/Specialist ❑ Legal matter ❑ Employment ❑ Government related ❑ Other

Date Range of Services: From ____ / ____ / ____ to ____ / ____ / ____ or ❑ All Dates of Service

Indicate the medical documents you agree to release by checking the box below:

❑ Recent Physical exam only - (No fee to release)
❑ Immunizations only - (No fee to release)
❑ Recent Lab Results only - (No fee to release)
❑ Correspondence in Record only
❑ **Full Medical Record only**
❑ Other: (specify) _____

❑ Dental **Record** Only ❑ Dental **X-rays** Only ❑ Dental **Record with X-rays**

Indicate any additional documents that you agree to release by checking the box below.

***These documents will not be released without your consent*!**

❑ Alcohol or Drug Abuse Treatment*
❑ Domestic Violence Treatment/Counseling
❑ Sexually Transmitted Diseases
❑ Sexual Assault
❑ Genetic Information
❑ Family Planning Services
❑ HIV/AIDS Results or Information
❑ Behavioral Health/ Psychotherapy (Initial intake, most recent treatment plan/discharge/transfer summary

*Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2)

DELIVERY METHODS - Please deliver my records:

❑ **As a paper printout. Please check the CRCH's site where you would like to pick up your record:** ❑ **Waltham** ❑ **Brighton**
❑ **On a CD or USB drive provided by patient** ❑ **Via the patient portal** ❑ **Via regular mail**
❑ **Via secure email:**_____ ❑ **Via fax:(** **) _____-_____**

See Other Side

Please mail my records to:

Recipient (Name and/or Facility):_____

Address:_____**City:**_____ **State:**_____ **Zip:**_____

Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____

I understand and agree that:

With my signature the information specified above will be released to the Recipient designated above.
The Authorization is valid for 90 days unless I indicate a different time or reason for expiration. See date ranges on other side.
Once the information has been released, the Health Center cannot guarantee that the Recipient will not re-disclose the information to a other party who may not be required to comply with state and/or federal laws governing the use and disclosure of protected health infor
mation (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.
I may revoke this Authorization at any time except to the extent that the Health Center has taken action in reliance on this Authorization.
I further understand that I must provide any notice of revocation in writing to the Medical Records Department at the address above.
Release may take **10-15** business days for records to be processed and released.
I will be notified when the records are ready for release.
I will be expected to pay for the information according to the payment policy below and as authorized by law.

- ◊ **No Cost**, for records released to medical or dental providers, or records obtained for a government program such as **MassHealth**
- ◊ **$6.50** for medical records released to the patient
- ◊ **$25**, for medical/dental records released to attorneys/insurance companies/others (postage included)

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/Guardian Signature: _____

❑ **I authorize my personal representative to pick up my records:**

Name: _____

Personal Representative Signature:_____ Date___ / ____ /___

FOR STAFF USE ONLY

❑ **Patient verification:** ❑ **Government issued ID** ❑ **Insurance card** ❑ **At least two identifiers**
❑ **Personal representative verification:** ❑ **Government issued ID**
❑ **Payment received $ _____**

Patient's MR # _____
Identity Confirmed/Record Released by CRCH staff member:_____ Date _____ / _____ / ____

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ENTREGA GENERAL DE REGISTROS MEDICOS/ AUTORIZACIÓN PARA EL USO O DIVULGACIÓN DE INFORMACIÓN DE SALUD PROTEGIDA

Al firmar este Entrega General de Registros Médicos/ Autorización para el Uso o Divulgación de Información de Salud Protegida ("Autorización), Yo autorizo al Centro de Salud entregar mi información de salud protegida ("PHI") según se especifica aquí a las siguientes personas/ entidades ("Receptor")

Información del paciente:

Nombre del paciente _____ **Fecha de Nacimiento** _____ / _____ / _____
Apellido **Primer** **Segundo**

Otros nombre(s) utilizado aquí: _____ **Teléfono:** (_____) _____ - _____

Calle: _____**Ciudad**_____**Estado**_____**Codigo Postal**_____

Correo electrónico: _____@_____._____

Motivo de la solicitud: ❑ petición mía (solo el paciente puede marcar esta) ❑ Transferencia ❑ Referido/Especialista
❑ Fines legales ❑ Fines de trabajo ❑ Asuntos de gobierno ❑ Otro _____

Fechas de servicio del ____ / ____ / ____ al____ / ____ / ____ o ❑ Todas las fechas de servicio

Indique los <u>documentos médicos</u> que usted autoriza que se le entregue marcando las casillas indicadas:

❑ Examen físico reciente solamente - (gratis)
❑ Vacunas solamente - (gratis)
❑ Resultados recientes de laboratorio solamente – (gratis)
❑ Correspondencia en el expediente solamente
❑ **Expediente médico completo** solamente
❑ Otro: (Especifique)_____

❑ Solamente el expediente dental
❑ Rayos equis dentales solamente
❑ Expediente dental y rayos equis

Indique los <u>documentos adicionales</u> que ústed está de acuerdo que se le entrequen <u>marcando y poniendo sus iniciales</u> en las casillas indicadas. ***Estos documentos <u>no serán entregados</u> sin su consentimiento***.

❑ Tratamiento de abuso de Alcohol o Droga*
❑ Tratamiento de Violencia Domestica/consejería
❑ Enfermedades de transmisión sexual
❑ Asalto Sexual
❑ Servicios de planificación familiar
❑ Salud Mental/ Psicoterapia (Registro inicial,
❑ VIH/SIDA plan de tratamiento mas reciente/dado de alta/resumen de transferencia)
❑ Otro: (Especifique) _____

*protegido por las Reglas Federales de Confidencialidad 42 CFR Parte 2 (REGLAS FEDERALES PROHIBEN CUALQUIER OTRA LIBERACION DE ESTA INFORMACION A MENOS QUE LIBERACION ADICIONAL ESTE EXPRESAMENTE PERMITIDA O UN CONSENTIMIENTO ESCRITO POR LA PERSONA A QUIEN PERTENECE O SEGUN ESTA PERMITIDO POR 42 CFR PARTE 2)

Metodo de entrega - por favor entregue los documentos:

❑ **Imprimidos (por favor cheque en que local quiere recoger sus documentos):** ❑ **Waltham** ❑ **Brighton**
❑ **En un CD o USB que el paciente provee** ❑ **Por el portal del paciente** ❑ **Por correo normal**
❑ **Por un email seguro:**_____ ❑ **Por fax:(** **) _____-_____**

Por favor mande mis documentos a:

Recipiente (nombre or lugar):_____

Calle:_____**Ciudad:**_____ **Estado:**_____ **Código:**_____

Teléfono: (_____) _____ - _____ **Fax: (_____) _____ - _____**

Yo entiendo y estoy de acuerdo que:

1. Con mi firma la información especificada arriba se le entregara al Destinario asignado anteriormente.
2. La Autorización es valida por 90 días a menos que indique un tiempo o razón diferente para la expiración.
3. Una vez que la información ha sido entregada, el Centro de Salud no puede garantizar que el destinario no volverá a divulgar la información a otra persona que no necesite cumplir con las leyes estatales y/o federales que rigen el uso y divulgación de información de salud protegida (PHI) y, en tal caso, el PHI descrito arriba puede ser revelada y ya no estar protegida por las leyes que rigen la privacidad de la información medica.
4. Puedo revocar esta Autorización en cualquier momento, excepto cuando el Centro de Salud ha implementado alguna acción basada en esta autorización.
5. Entiendo que debo proporcionar cualquier notificación de revocación por escrito al Departamento de Registros Medico en la dirección de arriba.
6. Puede tomar de 10-15 días laborables para que los registros sean procesados y entregados.
7. Se me notificará cuando los registros estén listo para entregar/recoger, a menos que solicite ser enviados por fax o correo directamente.
8. Tengo que pagar por la información de acuerdo con la póliza de pago siguiente y según autorizado por la ley. Se requiere pago adelantado para procesar la entrega.
   - ◊ **Sin Costo**, registros entregados a proveedores médicos o dentales
   - ◊ **$6.50 por documentos entregados al paciente**
   - ◊ **$25**, registro medico/dental entregado a abogados/compañías de seguro/otros (gastos de correo estan incluídos)

He leído cuidadosamente y comprendo los términos de esta autorización. He tenido la oportunidad de hacer preguntas sobre el uso y divulgación de mi información de salud. Con mi firma abajo, por la presente, voluntariamente autorizo la divulgación de la información de salud protegida a la persona/entidad designada como se especifico anteriormente. Doy mi permiso para compartir mi información de salud protegida, que puede incluir información protegida o privilegiada, por escrito y/u otro formato almacenado.

Firma del paciente o guardián_____

❑ **Yo autorizo que mi representante personal recoja mis documentos:**

Nombre: _____

Firma: _____ **Fecha: _____/_____/_____**

FOR STAFF USE ONLY

❑ **Patient verification:** ❑ **Government issued ID** ❑ **Insurance card** ❑ **At least two identifiers**

❑ **Personal representative verification:** ❑ **Government issued ID**

❑ **Payment received $ _____**

Patient's MR # _____

Identity Confirmed/Record Released by CRCH staff member:_____ **Date _____ / _____ / ____**

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AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

By signing this Authorization to obtain Protected Health Information ("Authorization"), I hereby authorize the following persons/entities ("Recipient"), to release my protected health information ("PHI") as specified herein to the Health Center

Patient's Information:

Patient's Name _____ Patient's Date of Birth: _____ / _____ / _____
Last First Middle
Other name(s) used as a patient here: _____
Telephone: (_____) _____ - _____ Email: _____
Address: _____City_____State_____Zip_____

Who has your records now?

Recipient (Name and/or Facility):_____

Address:_____City:_____ State:_____ Zip:_____

Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____ Email:_____

Information to be released to Charles River Community Health:

Date Range of Services: From ____/_____/_____ to ____/_____/_____ or ❑ <u>All</u> dates of service

Indicate the <u>medical documents</u> you agree to release by checking the boxes below:

- ❑ Medical Records (office visits, procedures, labs, PAPs/HPV tests, cancer screenings, and any in-house specialist notes)
- ❑ Correspondence in Record
- ❑ Recent Physical Exam) Only
- ❑ Recent Lab Results Only
- ❑ Immunizations
- ❑ Colonoscopy and Pathology Reports Only
- ❑ Other (specify): _____

Indicate any <u>additional documents</u> that you agree to release by <u>checking the box</u> below. *These documents <u>will not</u> be released without your consent*!

- ❑ Alcohol or Drug Abuse Treatment*
- ❑ Domestic Violence Treatment/Counseling
- ❑ Sexually Transmitted Diseases
- ❑ Sexual Assault
- ❑ Genetic Information
- ❑ Family Planning Services
- ❑ HIV/AIDS Results or Information
- ❑ Other (specify): _____
- ❑ Behavioral Health/ Psychotherapy (Initial intake, most recent most recent treatment plan/discharge/transfer summary)

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Dental Records - Indicate the <u>dental documents</u> you agree to release by checking and initialing the boxes below:

❑ _____ Dental **Record** Only ❑ _____ Dental **X-rays** Only ❑ _____ Dental **Record with X-rays**

Reason for Request:

❑ **Personal use** ❑ **Transfer of care** ❑ **Referral/Specialist** ❑ **Other:**_____

I understand and agree that:

1. With my signature, the information specified above will be released from the Recipient designated above to the Health Center
2. The Authorization is valid for 90 days unless I indicate a different time or reason for expiration. See service date ranges on other side.
3. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from the Health Center, except when: (i) my refusal may limit the Health Center's ability to provide safe and effective care; (ii) I am receiving research-related treatments; or (iii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these disclosures apply, my refusal to sign an authorization may result in my not obtaining treatment from the Health Center.

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 Personal Representative's Signature: _____

Name (printed):_____ **Date: ____ / ____ /____**

FOR STAFF USE ONLY

Primary Care Provider:_____

Patient's MRN:_____