



**AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: _____			
Last	First	MI	
Address: _____			
Street (include Apt #, if applicable)			
_____			
City	State	Zip Code	
Birth Date ____/____/____ Telephone # _____			

**I hereby authorize Harvard Street Neighborhood Health Center to release my protected health information described below (“PHI”) to the following individual or organization:**

Entity/Name: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

**PHI TO BE RELEASED (Please be specific and enter date of service if known):**

- Entire medical record \_\_\_\_\_ (excluding)
- Medical Record Abstract (e.g., H&P Operative Rpt, discharge summary Consults, labs, x-rays, pathology)
- Clinic notes, specify clinic name  Pathology Reports
- Consultation Reports  MRI Reports
- Medication Records  Itemized Bill
- Other (specify content) \_\_\_\_\_

**I request the release of the specifically protected or privileged categories of information where I have signed below.** (Harvard Street Neighborhood Health Center will not disclose the following documentation unless you check the box and provide an additional signature).

Release	Signature	Release	Signature
<input type="checkbox"/> HIV/AIDS Test Results		<input type="checkbox"/> Sexually Transmitted Disease (STDS)	
<input type="checkbox"/> Alcohol & Drug Abuse Records*		<input type="checkbox"/> Relate to diagnosis/or treatment of Hepatitis	
<input type="checkbox"/> Psychiatric Records or Information**		<input type="checkbox"/> Social Work Counseling/Therapy	
<input type="checkbox"/> Genetic Counseling/Records		<input type="checkbox"/> Commonwealth of Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling	

\* Only applicable to records that are created by an “individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment” (see 42 CFR Part 2). This authorization is not valid for use or disclosure of substance use disorder counseling notes. This authorization does not include records created or maintained by a general medical facility.  
Notice to recipient of these records: 42 CFR Part 2 prohibits unauthorized use or disclosure of these records.

\*\*This authorization is not valid for use or disclosure of psychotherapy notes.

**PURPOSE OF RELEASE.** The information is being released for the following purpose(s):

- At the Request of Patient       Inspection/Changing Physicians       Consultation       School
- Legal       Other (specify) \_\_\_\_\_

*For Alcohol & Drug Abuse records, check the following to disclose your Alcohol & Drug Abuse records for uses and disclosures for treatment, payment, and health care operations:*

- For treatment, payment, and health care operations.

**By signing below, I, the Patient, or Legal Representative of the Patient, agree to the following statements:**

1. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Harvard Street Neighborhood Health Center will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure.
2. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy and/or state regulations, except as otherwise may be provided by HIPAA and 42 CFR Part 2. However, the recipient may be prohibited from disclosing alcohol and drug abuse records in the event such records were not disclosed for treatment, payment, or health care operations. For alcohol and drug abuse records disclosed for the purpose of treatment, payment, or health care operations, I understand that such records may be redisclosed in accordance with the permissions contained in the HIPAA regulations and no longer protected by Part 2, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against me. I understand that if I refuse to consent to disclosure of my alcohol and drug abuse records for treatment, payment, and health care operations such refusal may impact the ability of my providers or payors to perform such services or activities.
3. I understand that I may inspect or copy the information to be disclosed, for a reasonable charge, and that I receive a copy of this form after I sign it.
4. I understand that I have the right to withdraw my authorization at any time, except to the extent information has already been released in reliance on this authorization. I understand that to revoke this authorization, I must do so in writing and send my written revocation to the Director of Medical Records at the address at the top of this form.
5. I understand that unless I revoke my authorization earlier, this authorization will expire automatically as follows: \_\_\_\_\_ [Please insert: Date, event, or condition upon which authorization will expire]. If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire **one year** from the date of the signature listed below.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of my condition, to those persons or entities listed above.

**Signature of Patient (18 years or older)** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of Legal Representative** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

\*Attach a copy of Legal Representative’s authority, as applicable (e.g. Parent, Court-appointed Guardian, Executor/Administrator, Health Care Proxy, Power of Attorney for Health Care)