## **Authorization for the Disclosure of Protected Health Information**



PATIENT NAME:		DOB//	of Central Massachusetts
-	h of Central MA to <u>RELEASE records TC</u> h of Central MA to <u>RECEIVE records FR</u>	-	e Provider below:
Where records are <b>GOING TO</b> or <b>CON</b>	MING FROM:		
Health Provider or otherAddress:		Telephone:	
I understand that my health record may incabortion, or other information I may conside	clude <i>general</i> information related to my ment r sensitive. <b>I understand that this authorization</b> ease of the following information for dates of se	n pertains to information obtain	ained on or before the date this
THE I	PURPOSE OF THE RELEASE OF THIS INF	ORMATION IS FOR:	
☐ Appointment w/ Specialist ☐ Transferring Care to New Provider ☐ OTHER (specify)	☐ Attorney/Legal Case☐ Disability/Insurance Applic/Claim	☐ Personal Use ☐ Pre-employment	
· · · · · · (op-o),	Please check all that apply for release a	uthorization:	
GENERAL RECORDS			
<ul> <li>□ Cardiac/Heart Studies</li> <li>□ Consultations</li> <li>□ Discharge Summaries</li> <li>□ EEG/EMG/Sleep Studies</li> <li>□ Emergency Records</li> <li>□ OTHER (specify)</li> </ul>	<ul> <li>☐ Immunization Records</li> <li>☐ Laboratory Reports</li> <li>☐ Office/Clinic Notes for Dr</li> <li>☐ Operative/Procedure Reports</li> <li>☐ Pathology Reports</li> </ul>	☐ Inpatient informati☐ Problem List☐ Pulmonary/Lug Stu☐ Radiology/Ultrasou☐ Rehab Notes-PT/O	dies ınd Reports
STATUTORILY PROTECTED RECORDS			
☐ Abortion ☐ Alcohol/Drug Abuse ☐ Domestic Violence Counseling ☐ OTHER (specify)	☐ Genetic Testing ☐ HIV/AIDS Results/Treatment ☐ Psychiatric Health/Psychotherapy no	☐ Sexual Assault Cour ☐ Sexually Transmitte	_
<ul> <li>provide information to a third party (exame a limit may inspect or copy information to</li> <li>There may be a fee for photocopying</li> <li>Any disclosure carries the potential liability that may arise from the disclosure the right to revoke this authorized will not apply to information that</li> </ul>	be disclosed as provided in the Privacy No	tice. omen's Health of Central M en request to WHCMA at th to this authorization. Revo	Mass (WHCMA) from any legal ne address below. Revocation
If I fail to specify an expiration <u>date</u> , <u>ever</u> the signature below, except when Federa	s otherwise revoked this authorization will nt, or condition, this authorization shall be valued and or State regulations specify otherwish THE ABOVE STATEMENTS AND AUTH	valid for not more than nine se. In such situations, the sh	norter time period shall apply.
Signature of Patient/Parent/Legal Representa	ntive* Date	Signer's	Relationship
Witness to Signature *If signing as a legal representative, also prov	Date ide appropriate paperwork to support represen		e Only - Identification cense or Other)
<ul><li>□ 328 Shrewsbury Street-Suite 100, Wo</li><li>□ 340 Maple Street-Suite 125, Marlbord</li></ul>		$\square$ 325 Thompson Road, We $\square$ 164 South Street, South	

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