	Nashoba Valle	v Medical Cen	iter		
Patient Request / Author		•		Health Infor	mation
Medical Record #					
I hereby authorize Nashoba Valley Medical C medical records:	Center to use and/or dis	sclose the Protecte	ed Health Inforr	mation specified	d below from my
1) PATIENT NAME: (Please Print)	Date of Birth:				
Address:					
Street Contact Telephone Number(s):		City	State		Zip
Email: (if applicable)					
2) INFORMATION TO BE DISCLOSED TO:					
Person or Facility Name (Please print)		Fax #			
Address (Please print)	City	State Zip		Phone #	
Email: (if applicable)					
3) Preferred Delivery Method - Email Postal Mail to address in # 2 abo In Person Pick-Up	ve				
4) Treatment Dates From:	To:				
5) SPECIFIC RECORDS/REPORTS(S) TO B	E RELEASED:				
☐ Admission History and Physical ☐ Laborated ☐ Labora	oratory Results	Rehab Services (PT, OT, Speech)			
☐ Discharge Summary ☐ Imag	ging Reports (Specify C	T, X-Ray, MRI)			
☐ Consultation ☐ Path	nology Reports				
■ Emergency □Ope	rative Notes				
☐ EKG Reports					
6) RESTRICTED RELEASE: We will <u>not</u> disc signature:	close the following docu	ımentation <u>unless</u>	you check the	box and provid	le an additional
Release	Signature	Release		Signature	
Mental/Behavioral Health Provider Documentation*		☐ Genetic Testing/Test Results*			
☐ HIV/AIDS Screening Test Results		Alcohol*** Treatment**	Alcohol*** Treatment*** and/or Substance Abuse		
Confidential Communications with a Social Worker			Child/Elder Abuse and Neglect		
Rape/Sexual Assault Victim's Counseling		☐ Domestic Vi	☐ Domestic Violence Victim's Counseling		
Sexually Transmitted Disease					

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2



^{*} This authorization is not valid for use or disclosure of psychotherapy notes

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current
... condition or problem.

^{***}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." (42 CFR Part 2) Not required for records created or maintained by a general medical facility.

Nashoba Va Patient Request /Authorization to Use	Illey Medical Center	octod Hoalth Informati	on
	and/or DISCIUSE FIOLE	toteu meaitii iiiioiiiiati	UII .
7) EXCLUSION REQUEST: I request that the following admission(s) / visit(s) be specifically exservice)	ccluded from this request	(s	pecify dates of
8) PURPOSE OF THE DISCLOSURE: Medical Care Legal Insurance Person	onal D Other		
*fees may apply 9) TERM: This Authorization will remain in effect for one year or:			
Until Nashoba Valley Medical Center fulfills this reque			
From the date of this Authorization until the		20	
Until the following event occurs:			
Other:			
 10) REVOCATION: I understand that I may revoke this Authoriza writing at the address listed below. The revocation will be effective notice. I understand that the revocation will not have any effect on Authorization before it received my written notice of revocation. Attention Health Information Management Nashoba Valley Medical Center 200 Groton Road Ayer, MA 01432 978-784-9000 11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIG reason and that such refusal will not affect the commencement, co eligibility for benefits at Nashoba Valley Medical Center. 12) POTENTIAL FOR REDISCLOSURE: I understand that the prompty with federal and state privacy laws, and my Protected Heafederal law once it is disclosed by Nashoba Valley Medical Center. 13) ACCESS: I understand that in certain circumstances Nashob of my Protected Health Information Nashoba Valley Medical Center I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have read and understand the terms of this Authorization and I have r	e immediately upon Nashoba any action taken by Nashoba and action taken by Nashoba and action taken by Nashoba action to the Nashoba act	a Valley Medical Center received by Valley Medical Center received with the Valley Medical Center of the Valley Medical Center o	eipt of my written eliance on this eliance of eliance on the eliance of eliance on the eliance of eliance on this eliance on this eliance on the eliance of eliance on this eliance on this eliance on this eliance on this eliance of eliance on this eliance of
40			
14) Signature of Patient		Date	
3		For Office Use:	
Printed Name of Patient	Witness	☐ I.D Verification_	
Authorized patient representative signature. If the patient is a min		sign this Authorization:	
Authorized patient representative signature. If the patient is a min	of of is office wise unable to	sign this Authorization.	
15)			
Signature of Personal Representative		Date	
Printed name of Patient Representative Rela	tionship to patient or authori	ty to act for natient	
Questions about the release should be directed to the hospita		., to dot for patient	
For Office Use:			
Copy of this authorization provided to the patient			
Copy of this authorization provided to the personal representation IS NOT VALID UNLESS ALL		COMPLETED AND FORM IS SI	GNED ON PAGE 2
	rint Name	Date	Time
	ithorization for Use and Disc 'S_ROI_14000 03/2023 Page		