

Carney Hospital
Patient Request / Authorization to Use and/or Disclose Protected Health Information

Medical Record # _____

I hereby authorize **Carney Hospital** to use and/or disclose the Protected Health Information specified below from my medical records:

1) PATIENT NAME: (Please Print) _____ Date of Birth: _____				
Address: _____				
Street	City	State	Zip	
Contact Telephone Number(s): _____				
Email: (if applicable) _____				
2) INFORMATION TO BE DISCLOSED TO:				
Person or Facility Name (Please print) _____				Fax # _____
Address (Please print) _____				Phone # _____
City	State	Zip		
Email: (if applicable) _____				

3) Preferred Delivery Method -

- Email
- Postal Mail to address in # 2 above
- In Person Pick-Up

4) Treatment Dates From: _____ **To:** _____

5) SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:

- | | | |
|---|---|--|
| <input type="checkbox"/> Admission History and Physical | <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Rehab Services (PT, OT, Speech) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Imaging Reports (Specify CT, X-Ray, MRI) | <input type="checkbox"/> Other (be specific) _____ |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Pathology Reports | _____ |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Operative Notes | _____ |
| <input type="checkbox"/> EKG Reports | | |

6) RESTRICTED RELEASE: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
<input type="checkbox"/> Mental/Behavioral Health Provider Documentation*		<input type="checkbox"/> Genetic Testing/Test Results*	
<input type="checkbox"/> HIV/AIDS Screening Test Results		<input type="checkbox"/> Alcohol*** and/or <input type="checkbox"/> Substance Abuse Treatment***	
<input type="checkbox"/> Confidential Communications with a Social Worker		<input type="checkbox"/> Child/Elder Abuse and Neglect	
<input type="checkbox"/> Rape/Sexual Assault Victim's Counseling		<input type="checkbox"/> Domestic Violence Victim's Counseling	
<input type="checkbox"/> Sexually Transmitted Disease			

* 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.

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



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7) EXCLUSION REQUEST:

I request that the following admission(s) / visit(s) be specifically excluded from this request _____ (specify dates of service)

8) PURPOSE OF THE DISCLOSURE:

Medical Care Legal Insurance Personal Other _____

*fees may apply

9) TERM: This Authorization will remain in effect for one year or:

- Until **Carney Hospital** fulfills this request.
- From the date of this Authorization until the _____ day of _____ 20_____
- Until the following event occurs: _____
- Other: _____

10) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of **Carney Hospital** in writing at the address listed below. The revocation will be effective immediately upon **Carney Hospital** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **Carney Hospital** reliance on this Authorization before it received my written notice of revocation.

Attention Health Information Management
Carney Hospital
 2100 Dorchester Ave.
 Dorchester, MA 02124
 617-296-4000

11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **Carney Hospital**.

12) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by **Carney Hospital**.

13) ACCESS: I understand that in certain circumstances **Carney Hospital** has the right to deny me access to all or portions of my Protected Health Information **Carney Hospital** will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize **Carney Hospital** to use and/or disclose my health information in the manner described above.

14) _____ Date _____
Signature of Patient

Printed Name of Patient

Witness

For Office Use: <input type="checkbox"/> I.D Verification _____
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Authorized patient representative signature. If the patient is a minor or is otherwise unable to sign this Authorization:

15) _____ Date _____
Signature of Personal Representative

Printed name of Patient Representative

Relationship to patient or authority to act for patient

Questions about the release should be directed to the hospital HIM Director.

For Office Use:

- Copy of this authorization provided to the patient
- Copy of this authorization provided to the personal representative

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

Signature of Personnel Completing Request

Print Name

Date

Time

