



Authorization to Use and/or Disclose Protected Health Information

Request Completed by _____ (staff initial) Medical Record # _____

I hereby authorize **GOOD SAMARITAN MEDICAL CENTER** 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) _____				
2) INFORMATION TO BE DISCLOSED TO:				
Person or Facility Name (Please print) _____				Fax # _____ Phone # _____
Address (Please print) _____		City	State	Zip

3) **TREATMENT DATES:** From _____ To _____

4) **SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:**

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

_____ |
|---|---|---|

5) **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) Does not include records created or maintained by a general medical facility.

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

7) **PURPOSE OF THE DISCLOSURE:**
 Medical Care Legal Insurance Personal Other _____

8) **TERM: This Authorization will remain in effect for one year or:**
 Until GOOD SAMARITAN MEDICAL CENTER fulfills this request.
 From the date of this Authorization until the _____ day of _____ 201_____
 Until the following event occurs: _____
 Other: _____

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

GOOD SAMARITAN MEDICAL CENTER
 235 North Pearl Street
 Brockton, Massachusetts
 02301

10) **EFFECT ON TREATMENT:** 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 at GOOD SAMARITAN MEDICAL CENTER.

11) **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 GOOD SAMARITAN MEDICAL CENTER.

12) **ACCESS:** I understand that in certain circumstances GOOD SAMARITAN MEDICAL CENTER has the right to deny me access to all or portions of my Protected Health Information GOOD SAMARITAN MEDICAL CENTER 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 GOOD SAMARITAN MEDICAL CENTER to use and/or disclose my health information in the manner described above.

13) _____ Date

Signature of Patient

For Office Use:
 I.D Verification _____

Printed Name of Patient

Witness

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

14) _____ Date

Signature of Personal Representative

Printed name of Patient Representative

15) _____
 Relationship to patient or authority to act for patient

Questions about the release should be directed to the Medical Records Department by contacting 508-427-3000.

For Office Use:
 Copy of this authorization provided to the patient
 Copy of this authorization provided to the personal representative
 form revised Oct-2013