Steward Medical Group Authorization to Use and Disclose Protect Health Information

Location Name:_____ **Practice ID#**_____

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____

Any other Previous Names: _____

Patient Address: _____ Phone # _____

City: _____ State _____ Zip: _____ EMAIL _____

I hereby Authorize Steward Medical Group To:

Please choose one: ◯ Release my medical record information to ◯ Obtain medical information from

Name/Facility: _____ Attention: _____

Address: _____ Phone #: _____

City: _____ State _____ Zip: _____ Fax #: _____

Purpose of Request (optional) ◯ Personal ◯ Referral or 2nd Opinion ◯ Legal ◯ Insurance ◯ Other _____

◯ Transfer from Practice/Reason? _____.

Specific Records/Report(s) to be released:

*** Please do not pre-pay. You will be invoiced for your selection by our vendor ***

◯ Please provide a 2 year abstract of my records.

◯ Other - please be specific, include dates and MD's under comments.

Comments

COPY FEE: *For Patient record requests - Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record or more than the two year abstract, the rate will increase proportionately based on the cost. For all other release of information requests, the applicable US state statute governing fees for medical records will be applied.*

Restricted Authorization to Release Protected Information:

STOP **IMPORTANT -** It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section. Please do not skip any items as it could impact our ability to fulfill your request and cause delays.

Release Records? Check one

I ☐	**DO**	☐	**DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation *** released**.**
I ☐	**DO**	☐	**DO NOT** want **HIV/AIDS Screening Test Results** released
I ☐	**DO**	☐	**DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released
I ☐	**DO**	☐	**DO NOT** want **Genetic Testing/Test Results **** released
I ☐	**DO**	☐	**DO NOT** want **Confidential Communications with a Social Worker** released
I ☐	**DO**	☐	**DO NOT** want information about **Rape/Sexual Assault Victim Counseling** released
I ☐	**DO**	☐	**DO NOT** want **Child/Elder Abuse or Neglect & & Abuse of an Adult with a Disability** released
I ☐	**DO**	☐	**DO NOT** want information about **Sexually Transmitted Disease (STD)** released
I ☐	**DO**	☐	**DO NOT** want information about **Domestic Violence Victim Counseling** released

* 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 test done to diagnose a current condition or problem. This includes information related to the testing of embryos created during IVF.

*** 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.

Sign Here **Date Here**

Signature of Patient **Date**

Parent/Legally Recognized Representative Signature** **Relationship/authority to act for patient** **Date**

Term: This Authorization will remain in effect until Steward Medical Group (SMG) fulfills this request.

Revocation: I understand that I may revoke this Authorization at any time by requesting it of Steward Medical Group in writing at the address listed below. The revocation will be effective immediately upon Steward Medical Group's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Steward Medical Group in reliance on this Authorization before it received my written notice of revocation.

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 Steward Medical Group

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 SMG.

Access: I understand that in certain circumstances Steward Medical Group has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.

Please mail your completed form to your provider's office. Please do not mail your completed form to 9 Galen Street, Watertown, Massachusetts as this is not a provider location and we do not have the ability to process the forms there.

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