ANNA JAQUES HOSPITAL

Health Information Management
25 Highland Avenue
Newburyport, MA 01950
978-463-1155
Fax 978-463-1154

Authorization for Release of Protected or Privileged Health Information

❑ RELEASE COPIES OF HEALTH/MEDICAL RECORD ❑ REVIEW HEALTH/MEDICAL RECORD

Patient Name (Please Print)	**Patient Date of Birth**
Patient Medical Record #	
Patient Address (Street {apt #}, City, State ZIP)	
Patient Telephone Contact #'s	

I, _____ ,
Patient Name

do hereby authorize _____ to release my protected health information including copies of my medical record of care received at your facility to the following person(s) at the locations/facilities listed below, for the purposes described:

Person(s)/Facility/Address (*include Name and Address***)**

1. _____
2. _____

Purpose* (*check appropriate box*)

- ❑ Medical Care
- ❑ Insurance*
- ❑ Legal Matter*
- ❑ Personal*
- ❑ School
- ❑ Other* (*please specify*) _____

Information to be Released (*please check all that apply and specify dates***)**

❑ Clinic Visit Notes *Date:*	❑ Pathology Reports *Date:*
❑ Operative Reports *Date:*	❑ Radiation Reports *Date:*
❑ Discharge Summary *Date:*	❑ Lab Reports *Date:*
❑ X-rays/Scan Reports *Date:*	❑ Photographs* *Date:*
❑ Medical Record Abstract (i.e. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary): *Date:*	
❑ Other (*please specify*) *Date:*	

* Please refer to the Anna Jaques Hospital Privacy Notice for information on copying fees that may be associated with this request (there may be additional charges for copies of photographs)

Release of Specifically Protected or Privileged Health Information

I request the release of the specific categories of information that I have *INITIALED* below:

_____ HIV test results (Patient Authorization for EACH Release Request) Specify Date(s) _____

_____ Genetic test results (excludes therapeutic genetic tests) Specify type of test _____

_____ Alcohol and Drug Abuse Records (Protected by Federal Confidentiality Rules 42 CFR Part 2) (*Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted or written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2*)

_____ Other(s) Specify: _____

Confidential Details of:

_____ Psychotherapy (from a Psychiatrist, Psychologist or Mental Health Clinical Nurse Specialist)

_____ Social Work Counseling/Therapy

_____ Domestic Violence Victims Counseling

_____ Sexual Assault Counseling

I understand that:

I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management at Anna Jaques Hospital or the Office Manager in my physician's office. Authorization may be withdrawn except for the following:

- To the extent that action has been taken in reliance on this authorization
- If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected.

Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Anna Jaques Hospital.

I understand that this authorization will automatically expire (*please check one*):

❑ In 6 months ❑ Upon a specific event (specify event)_____

I have carefully read and understand the above, have had any questions explained to my satisfaction and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

_____ _____

Signature of Patient ***Date***

_____

Print *Name*

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian or other legal representative is required.

_____ _____

Signature of Legal Representative ***Date***

_____ _____

Print *Name* ***Relationship to Patient***

FOR INTERNAL USE ONLY

Information Released/Reviewed by:_____ Date:_____

Clinic/Office: