SIGNATURE HEALTHCARE
680 Centre Street, Brockton, MA 02302
Ph: 508-941-7069 | Fax: 478-246-4175 | MySignatureCare.org

MRN #:_____

ID Verification #:_____

Authorization Release of Information

Patient Name:_____ Date of Birth:_____
(First Name) (Middle Initial) (Last Name)

Patient Address_____ Phone Number:_____

A. Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written form.

I Need Records From:
Name of Facility: _____
Address:_____
Fax Number: _____ Phone: Number: _____

Records Are Going To:
Name of Facility: _____
Address:_____
Fax Number: _____ Phone: Number: _____

B. Reason for Release of Records: (a copy service fee will be charged for personal copies)
☐ Transfer of Record ☐ Personal Copy ☐ Change PCP_____ ☐ Other_____

C. Visit Dates: *from*_____ *to*_____

D. What Records do you wish to obtain copies of from Signature Healthcare?
☐ Hospital Records ☐ Clinic Records **Physician Name:**_____

E. Documents to be released: (please check the documents you wish to obtain/have released)

- ☐ Entire Medical Record
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Radiology Reports
- ☐ Immunization/Physical Records
- ☐ Medication List
- ☐ Emergency Department Reports
- ☐ Lab/Pathology Reports
- ☐ Operative Notes
- ☐ Other

F. To request the release of specifically protected or privileged information you must initial below:

- ☐ Alcohol or Drug Abuse Treatment
- ☐ Sexually Transmitted Diseases
- ☐ Domestic Violence Victim's counseling
- ☐ Sexual Assault Victim's Counseling
- ☐ Communication between patient and Social Worker
- ☐ Psychiatric Health – mental health information Including communication between a patient and a Psychiatrist, licensed Psychologist, and Psychiatric Clinical Nurse Specialist.
- ☐ HIV/AIDS diagnosis and/or treatment: I specifically give permission to share information. Initial here to specifically authorize its release _____as required by M.G.L., c.111, §
- ☐ Genetics Testing: I specifically give permission to share information in my record about my genetics testing (excludes Therapeutic genetic tests). Initial here to Specifically authorize its release _____as required by M.G.L. c.111, 70G. (We do not disclose genetic information for insurance underwriting purposes.)

**Please complete the additional information on the back of this page.*

G. I understand and agree that:

• The information which I authorize for release may be re-sent by the recipient and no longer protected by federal privacy regulations • I will be charged a fee for information that is sent directly to me • I decline the opportunity to inspect or copy the information released • I have received a copy of this authorization • 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	• I may take back this authorization at any time by notifying the Physician / hospital / clinic / organization from whom I am requesting this information, provided that the information has not already been released • This authorization is voluntary • My treatment will not be conditioned on the completion of this authorization. • My questions about this authorization form have been answered

H. I understand that this authorization expires 12 months from the date it was signed OR as specified: ___/___/___
If not specified, this authorization will expire 12 months from the date it was received. The authorization may be revoked in writing by me or my Legal representative at any time prior to the expiration date.

X._____ **or X.**_____ **and**_____ **Date:**_____

Patient's Signature | **Person Authorized to Sign for Patient** | **Relationship to Patient**