HARBOR HEALTH

AUTHORIZATION FOR RELEASE OF PROTECTED AND PRIVILEGED HEALTH INFORMATION

Harbor Health Services, Inc.
1135 Morton Street
Mattapan, MA 02126
(617) 533-2300

Daniel Driscoll – Neponset Health Center
398 Neponset Ave
Dorchester, MA 02122
(617) 282-3200

Geiger Gibson Community Health Center
250 Mount Vernon Street
Dorchester, MA 02125
(617) 288-1140

Harbor Community Health Center – Hyannis
735 Attucks Lane
Hyannis, MA 02601
(508) 778-0300

Harbor Community Health Center – Plymouth
10 Cordage Park Circle
Suite 115
Plymouth, MA 02360
(508) 778-5470

Ellen Jones Community Dental Center
Patriot Square
516 Route 134, Unit 12
South Dennis, MA 02660
(508) 778-5400

Elder Service Plan – Mattapan
1135 Morton Street
Mattapan, MA 02126
(617) 533-2400

Elder Service Plan – Brockton
479 Torrey Street
Brockton, MA 02301
(774) 470-6700

DotHouse Health – WIC
1353 Dorchester Ave
Dorchester, MA 02122
(617) 825-0805

Codman Square – WIC
673 Washington Street
Dorchester, MA 02124
(617) 825-3822

Patient name	Date of birth		
Patient street address	City	State	ZIP
Home phone	Work phone		

1. Purpose of the disclosure (Please check one):

- ○ Personal
- ○ Legal
- ○ Inspection
- ○ Insurance
- ○ Medical Care
- ○ School
- ○ Transfer of care
- ○ Other (please specify): _____

2. Information to be released below. (Please check all that you authorize):
Specify Dates- From _____/_____/_____ through _____/_____/_____

_____ Visit Notes
_____ Photographs/Videos
_____ Dental X-Ray
_____ Billing Records
_____ Lab Results
_____ Dental Records
_____ Entire Patient Medical Record (Includes forms filled out by our providers)
_____ Other (Please specify): _____

* **Please note:** If you are signed up for our patient portal, the following records are available to you on the portal now: labs results, immunizations history and visit notes.

3. How and to whom the information is released:

Select a method below:

- ○ I will pick up my records at my Harbor Health location, please specify: _____
- ○ I authorize _____ (enter individual's name) to pick up the records on my behalf. ****Please note**: This individual will be required to present a photo ID when picking up your records.
- ○ Mail the records to my address listed above.
- ○ I give permission for Harbor Health Services, Inc. to send my records
  To: _____

Send by:

○ Mail
Street Address_____
City_____
State_____ Zip Code_____

○ Fax
Fax Number _____
Attention to_____

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4. Please initial all that you give permission to release (if in your medical record):

_____ HIV tests results and treatment (Patient Authorization Required for Each Release)

_____ 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 BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

_____ Details of mental health diagnosis and/or treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC)

_____ Details of sexually transmitted disease(s)

_____ Details of domestic violence

_____ Details of sexual assault

_____ Confidential communications between patient and social worker

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5. By signing this form, you agree to the following:

- I understand that Harbor Health cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Harbor Health may or may not protect this information once it has been released to the recipient.
- I understand that I may inspect or copy the information used and disclosed.
- I am voluntarily authorizing this information to be released and I understand I may revoke this authorization at any time by notifying the Medical Record Department at Harbor Health in writing, provided the information has not already been disclosed.
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form.
- My questions have been answered related to the disclosure of this information
- I understand this authorization release of information will expire after **6 months** unless I specify a date it should expire here: _____

Patient's Signature (18 years or older)**:** _____

Legal Representative Signature: _____
(If authorized representative, please sign and attach copies of supporting legal documentation.)

Relationship of representative to patient: _____

Print Name: _____

Date: _____

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Instructions:

Please follow these instructions carefully when completing the authorization form. The form must be entirely completed and signed. Failure to do so may result in a delay in processing this request to release your medical record information. The requestor must be a patient or patient's guardian/legal representative.

A. Fill the top box with the patient name, address, date of birth, address and telephone number whose protected health information ("medical record") is being released.

1- Purpose of disclosure: Check one that applies to the reason for disclosure.

2- Information to be released: Insert the treatment date or date range of the medical record you are requesting to be released. Check all record type that you authorize to be released. All unchecked record type will not be released.

3- How and to whom the information is released: select a method on how you want the records to be released. If the records are being mailed to an address different than the one on file please print the name in the TO field, address and telephone number of the organization or individual from whom the medical record is requested. Note: Faxing service is available for urgent medical care or records type containing less than 10 pages only. If someone other than the patient will be picking up the records, this person will be required to present a photo ID when picking up your records.

4- Privileged or Specifically Protected Information: Initial each statement to indicate each type of information you are authorizing us for release. If you had testing, diagnosis or treatment for any condition(s) as described under the "specifically protected" section, it is required that you place your initials in front of the section(s) that describes the type of information to be released. This information is Protected by Federal Confidentiality Rules 42 CFR Part 2 (federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.)

5- Understanding/Signatures: Please read the important information in this section. Insert the expiration date. If not specified; then this authorization will be valid for 6 months. Patient or Authorized Representative Signature: The patient whose medical record is being released must sign and date the authorization OR the Authorized Representative of the patient to whom the medical record pertains must sign and date the authorization. **Please note:** If the individual signing the authorization form is a Guardian, Executor of the Estate, Healthcare Proxy or Power of Attorney for the patient, that person must submit a copy of the appropriate legal document, which proves authority to act on behalf of the patient. This must accompany the authorization form.

You can either mail this form to the address listed below or you can fill out and drop off in your next visit to any of our clinic. Stop by the front desk for more information or call us at 617-533-3042.

Harbor Health Services
Attn: Medical Records
398 Neponset Ave.
Boston, MA 02122

We will mail your records to the address specified on the release of information form. For patient privacy protection, we do not fax or email medical records (except in the case of emergency care) to the provider or records type containing less than 10 pages.

The average turnaround time to obtain copies of medical records is usually 7 business days. For urgent requests please call us at 617-533-3042.