Harbor Health Services, Inc
Authorization for Release of Protected Health Information

Daniel Driscoll Neponset Health Center 398 Neponset Avenue, Dorchester, MA 02122 ph: 617-282-3200
Geiger Gibson Community Health Center 250 Mt. Vernon Street, Dorchester, MA 02125 ph: 617-288-1140
Harbor Community Health Hyannis 735 Attucks Lane Hyannis, MA 02601
Harbor Community Health Plymouth 10 Cordage Park Plymouth, MA 02360

I hereby authorize the release of medical information:

1. From: _____ To: _____

Address: _____ _____

_____ _____

Purpose of release (check appropriate box)

☐Medical Care ☐ Insurance ☐ Legal Matter ☐ Personal ☐ Other _____

I authorize the use, disclosure and release with the understanding that it may include specifically protected or privileged information in one or more of the following categories: ☐ information related to alcohol or drug abuse;
☐ communications between a patient and social worker; ☐ information related to sexually transmitted diseases; ☐ communication between the patient and a psychotherapist (including psychiatrists, licensed psychologists and psychiatric clinical nurse specialist);
☐ genetic test results (excludes therapeutic genetic tests); ☐ domestic violence victims counseling; ☐ sexual assault counseling
* Check all you are authorizing for release

I HAVE PLACED A LINE THROUGH AND INITIALED ANY PORTION OF THE PARAGRAPH ABOVE THAT LISTS INFORMATION WHICH I DO NOT WANT RELEASED

I understand that the information I authorize an individual organization to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may inspect or copy the information used and disclosed. I know that I may revoke this authorization at any time by notifying the above named organization in writing, provided the information has not already been disclosed. I know that this authorization is voluntary. I understand that treatment will not be conditioned on the completion of this authorization. I know that I have the right to request and receive a Harbor Health Services, Inc Notice of Patient Privacy Rights.

Name of Patient: _____

Date of Birth: _____/_____/_____ MRN: _____

Patient Address: _____

_____

Please check information to be released below: from _____/_____/_____ through _____/_____/_____

☐ Visit Notes	☐ Pathology Reports
☐ Photographs/Videos/Text	☐ Radiation Reports
☐ Operative Reports	☐ Lab Reports
☐ Discharge Summary	☐ Entire Patient Medical Record
☐ X-rays/X-ray reports (please specify) _____	☐ Other (please specify_____

This authorization expires in (please check appropriate box): ☐ 3 months ☐ 6 months ☐ other _____/_____/_____

(If not specified, all authorizations will expire 12 months from the date this form was signed)

_____ _____
Signature of Patient or Legal Representative HHSI Authorized Agent/Witness Signature

_____ _____/_____/_____
Print Name & relationship if other than patient Date

FOR RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42) CFR PART 2:
This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SPECIAL AUTHORIZATION UNDER MASSACHUSETTS GENERAL LAW CHAPTER 111, § 70F FOR DISCLOSURE OF MEDICAL RECORDS INFORMATION INCLUDING THE RELEASE OF HIV ANTIGEN OR ANTIBODY TESTING

I hereby authorize _____

located at _____or their agents to release and disclose my individually identifiable health information, specifically information and medical records regarding the history or results of HIV testing, and/or treatment for AIDS to:

_____

_____

Purpose of release (check appropriate box below)

☐ Medical Care ☐ Insurance ☐ Legal Matter ☐ Personal ☐ Other _____

I understand that the medical record contains information about testing for HIV antibody or antigen. I do herein expressly and voluntarily consent to disclosure of this medical record information for the purpose or need stated above. I further understand that I am not giving permission for any disclosure other than as specified above.

I understand that I may inspect or copy the information used and disclosed. I know that I may revoke this authorization at any time by notifying the above named organization in writing, provided the information has not already been disclosed. I know that this authorization is voluntary. I understand that treatment will not be conditioned on the completion of this authorization. I know I have a right to request and receive Harbor Health Services, Inc Notice of Privacy Practices.

Name of Patient: _____

Date of Birth: _____/_____/_____ MRN: _____

Patient Address: _____

_____

_____ Date: _____/_____/_____
Signature of Patient or Legal Representative

_____
Print Signature

_____ Date: _____/_____/_____
HHSI Signature of Authorized Agent

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