Heywood Healthcare
Athol Hospital | Heywood Hospital | Heywood Medical Group

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

☐ Heywood Hospital ☐ Athol Hospital ☐ Heywood Medical Group ☐ Winchendon Health Center

MRN: _____

Patient Name: DOB: Phone: Email:

Address:

Street City State Zip

I authorize my requested healthcare information to be released FROM: (i.e. who has the records now?)

Facility/Organization/Company/Person Phone Fax

Address: City State Zip

I authorize my requested healthcare information to be released TO: (i.e. who should the requested records be sent to?)

Facility/Organization/Company/Person Phone Fax Email

Address: City State Zip

The Purpose for this Request is: ☐ Transfer Care ☐ Personal Use* ☐ School ☐ Attorney/Legal ☐ Disability ☐ Employment ☐ Insurance ☐ Worker's Compensation ☐ Other

***If Personal Use, Preferred Delivery Method:** ☐ In-Person Pick-up ☐ U.S. Mail ☐ Email ☐ Fax

Specific Information to be Released :(subject to copy fees allowed by the state of MA)

☐ entire medical record (for Heywood Healthcare entity indicated above)

☐ Health Record (Date(s) of Service) from: _____ to: _____

☐ Discharge summary, ☐ Cardio/Pulmonary reports, ☐ Operative reports, ☐ X ray reports, ☐ Rehab Notes, ☐ EMG/ EKG/ Tracing/report, ☐ Last History and Physical, ☐ Prenatal/OB Record, ☐ Abstract, ☐ Clinic records, ☐ Surgical reports, ☐ Medication List, ☐ Laboratory Results, ☐ Consultation Reports, ☐ Diagnostic Imaging Reports, ☐ Emergency Room Records, ☐Other:_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Heywood Healthcare. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless otherwise revoked, **this authorization will expire on (specify date):____/____/_____,** If I have not specified an earlier date, this authorization is valid for one calendar year after the date signed unless canceled in writing. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I may receive a copy of this form.

Information that you authorize to be disclosed may be subject to re-disclosure and no longer protected by law to the extent applicable. I understand that my record may contain information that is considered sensitive under the law. PHI cannot be used or disclosed unless you specifically authorize such use or disclosure under 42-CFR Part 2 of the federal confidentiality regulations. This information shall not be transmitted without specific authorization as provided in these regulations.

My initials below indicate that I permit the following information, if applicable in my health record, to be released:

_____ HIV/AIDS-Related Information, including status, results, treatments, diagnoses and/or referrals

_____ Drug and Alcohol Abuse Information, including status, results, treatments, diagnoses and/or referrals

_____ Behavioral Health Information, including status, results, treatments, diagnoses and/or referrals

_____ Communicable Diseases, including status, results, treatments, diagnoses and/or referrals

_____ _____ _____ _____

Signature of Patient or Legal Representative Date Signature of Witness (if signed by legal representative) Date

OFFICE USE ONLY: ID Verified: ☐ Yes ☐ No Date Released: _____Fee Collected: ☐ Yes ☐ No AMT: _____

Legal Representative documentation provided: ☐ Yes ☐ No specify;_____ Staff Initials: _____