Authorization to Release, Disclose or Use Protected Health Information (PHI)

PATIENT'S NAME:_________________________DATE OF BIRTH:_________

1. This Authorization will expire on:____________________ or upon the following event:______________________

TODAY'S DATE:____________ Valid for 1 year if no date or event given(high school graduation, transfer of records, etc.)

2. Protected health information shall be released:

TO:____

FROM :____

(fill in the name and address of the entity to receive/release the protected information.)

3. Please release the following information:

☐ Entire Medical Record **OR** ☐ Other(please specify)________________________________

4. To be released via (check one): ☐ Mail ☐ Pick Up in _________ office ☐ Talk To (phone/in person)

5. The protected health information will be released, disclosed or used for the following **purpose**.

☐ I am carrying the records to a specialist's office (no charge).

☐ I am requesting a copy for my personal use ($20 CHARGE).

☐ Other reason (may carry an $20 CHARGE): ____

Make my file inactive because:

☐ I am transferring to another office. **Send** the records directly to my new physician ($20 CHARGE).

☐ I am transferring to another office and will carry the records to my new physician ($20 CHARGE).

6. I am moving, my new address is ____

7. I understand that:

a) The purpose is provided above so that I can make a decision as to whether to allow the release of information.
b) The disclosing office will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI, except for minimum fees for copying and postage.
c) I do not have to sign this authorization in order to receive treatment.
d) When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule or other law protecting its confidentiality.
e) I have the right to revoke this authorization in writing, except where the office has acted in reliance upon it. My written revocation must be submitted to: **Privacy Officer, Pediatric & Adolescent Medicine, 2207 Boston Rd., Wilbraham MA 01095** OR to the Privacy Officer of the facility that is releasing information.
f) This form may be deemed INVALID if all sections are not completed.

8. I hereby authorize you to release, disclose or use the protected health information as indicated above from the medical records of the named patient above.

____ ____

Signature of Parent or Legal Guardian (or Patient if Applicable) Print Name of Person Signing ***and*** Relationship

IF 18 or over, PATIENT MUST SIGN. DATE:____________________________________

Would you like a copy of this signed authorization mailed to you when the records have been released?

☐ **NO** ☐ **YES: mailing address:**____

Internal Use Only:

ID Confirmed by (initial):________ **Circle**: Photo ID, Signature Compared or Personal Knowledge

If required, $20 Payment Received_____ Applied______ APPROVED BY PRIVACY OFFICER________

REV. 2/2016:kh