

Community Health Center of Franklin County, Inc.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:
Address:	Phone Number:

I hereby authorize Community Health Center of Franklin County, Inc. and its affiliates to:
 disclose protected health information to: request protected health information from:

Name:	
Address:	
City, State, Zip:	Telephone:

Please send to:

- Turners Falls Site: 338 Montague City Rd, Turners Falls, MA 01376 (413) 772-3748 Fax: (413)772-6366
 Orange Site: 450 West River St, Orange, MA 01364 (978)544-7800 Fax: (978)544-0025

Records to be disclosed: Medical Dental Other: _____

Information to be disclosed: Entire record Medical History and Visit Notes
 Diagnostic Tests Immunizations Hospital Records Surgical Reports
 Specialist Consults Other: _____

Period of Information: Entire period of care From _____ to _____

The purpose of this request is:

- | | | |
|--|---|---|
| <input type="checkbox"/> Coordinate care | <input type="checkbox"/> Personal use | <input type="checkbox"/> Leaving CHCFC/transfer |
| <input type="checkbox"/> Employment/school | <input type="checkbox"/> Disability/SSI | <input type="checkbox"/> Transferring to CHCFC |
| <input type="checkbox"/> Attorney/legal case | <input type="checkbox"/> Insurance | <input type="checkbox"/> Other: _____ |

Statutorily protected records are those records that require separate consent to release. If you want the following records released, you must **initial** next to the item:

- | | |
|---|-------------------------------------|
| ___ Substance abuse | ___ Domestic violence counseling |
| ___ Treatment by a mental health professional | ___ HIV/AIDS test results/treatment |
| ___ Sexual assault counseling | ___ Sexually transmitted diseases |
| | ___ Genetic testing results |

Expiration Terms: I understand that this authorization pertains to information obtained on or before the date signed. I authorize the release of information for the period:

From: _____ To: _____

Unless otherwise revoked, this authorization will expire on the following date, event, or condition (1 year from date signed if no other date or condition specified).

TURN OVER

I understand that:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I have a right to request a copy of this authorization.
- I may inspect or copy information to be disclosed. I understand that arrangements can be made to inspect my medical or billing record on-site by contacting the Health Information department.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release the Community Health Center of Franklin County, Inc. and its affiliates from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke the authorization at any time by presenting a written request to the Health Information department (Medical Records). Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- I understand that my health information may include *general* information related to my psychiatric health, drug/alcohol use, communicable diseases, sexual/reproductive history, family problems, or other information that I may consider sensitive. For purposes of safety and coordination of care, this will include information provided on my health history and all records pertaining to prescription medications when the request is for disclosure to another health care provider.

I have read and understand the above statements and authorize the disclosure of the information requested.

Signature of Patient, Parent, or Legal Representative	Date	Relationship to Patient
Witness to Signature	Date	Identification (for CHCFC use only)

OFFICE USE ONLY: Approved: _____ Date: _____ Completed: _____ Date: _____ Pages Copied: _____ Fee: _____ Paid _____ Waived _____ Amount _____
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