PATIENT NAME: ____________________ DATE OF BIRTH: ____________________
MEDICAL RECORD NUMBER: ____________________ PHONE #: ____________________

RELEASE FROM HOLYOKE MEDICAL CENTER (HMC): I authorize HMC to release my health information to:
Name: ____________________
Address: ____________________
What to Release: *Dates of Service:* ____________________
Please include the following information: ☐ Entire Record, ***OR*** the following (check all that apply)

- ☐ Abstract (Provider notes, test results)
- ☐ Lab results ☐ Pathology Reports
- ☐ Radiology Reports (X-Ray, MRI CT) ☐ Films
- ☐ Cardiology / EKG Reports
- ☐ Discharge Summary ☐ Other ____________________
- ☐ Operative Reports
- ☐ Work Connection (OHS / OHC / EHP)
- ☐ Behavioral Health
- ☐ Inpatient ☐ PHP / IOP ☐ Outpatient

Purpose of Request: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: ____________________

RELEASE TO HMC: I authorize ____________________ to release my health information to:
Holyoke Medical Center, Attention Dept. ____________________ 575 Beech St., Holyoke, MA 01040 *Fax: 413.534.2651*

What to Release: Dates of Service: ____________________
Please include the following information:

- ☐ Abstract (Provider notes, test results)
- ☐ Discharge/Transfer Summary
- ☐ Radiology Reports ☐ Films
- ☐ Operative Reports ☐ Laboratory & Pathology Reports
- ☐ Behavioral Health
- ☐ Psychosocial Assessment ☐ Medication Management Information
- ☐ Treatment Plan/Progress ☐ Presence/Progress/Participation Treatment
- ☐ Admission & Discharge note for hospitalization (dates) ____________________
- ☐ Other ____________________
- ☐ Other ____________________

Purpose of Request: ☐ Continuity of Care ☐ Legal ☐ Personal ☐ Other: ____________________

RELEASE OF PRIVILEGED INFORMATION:
_____ (Initials) **HIV/AIDS:** I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment related to Acquired Immune Deficiency Syndrome (AIDS) only to the person or organization named above and only for the purpose name above.
_____ (Initials) **GENETIC TESTING:** I hereby authorize release of protected health information pertaining to genetic test results only to the person or organization named above and only for the purpose name above.
_____ (Initials) **ALCOHOL and DRUG TREATMENT:** I hereby authorize release of treatment records of a licensed drug and alcohol treatment program to the person or organization named above and only for the purpose name above. I also understand that my Alcohol and Drug Abuse Records cannot be re-disclosed without my express authorization.
_____ (Initials) **INPATIENT PSYCHIATRIC RECORDS OR RECORDS OF A PSYCHOLOGIST OR PSYCHOTHERAPIST:** I hereby authorize release of psychiatric treatment records, and/or records of apsychologist or psychotherapist only to the person or organization named above and only for the purpose name above.
_____ **Domestic violence abuse counselor records** _____ **Social service records** _____ **Sexual assault counselor records**
_____ **Sexually transmitted disease records**

INDIVIDUAL RIGHTS: I understand the following:

- I have the right to revoke this authorization at any time.
- If I revoke this authorization I must do so in writing to the attention of the Medical Records Dept, HMC, 575 Beech St., Holyoke, MA 01040, or must contact the party whom I had authorized to release the information, if other than HMC.
- My right to revoke does not apply to information already released on the basis of this authorization.
- The privacy of my health records is protected under "HIPAA," 45 CFR, pts 160 & 164, and the privacy of any alcohol and/or drug treatment records are also protected under the Federal Confidentiality & Drug Abuse Records regulations, 42 CFR, pt 2.
- I understand that Holyoke Medical Center cannot guarantee that the Recipient will not re-disclose my health information to anyone else.
- There may be a charge for providing copies of medical records.

Expiration Date: This authorization will expire in one year unless revoked or otherwise specified to be the following date, event or condition:
(person's initials) __________ Conclusion of this Treatment Episode (person's initials) ______ Other: ____________________

Signature: ____________________ *Date:* ____________________

If not signed by person served, specify relationship: ☐ Parent ☐ Legal Guardian/Designee

Holyoke Medical Center
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION