Baystate Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____

DOB: _____

Medical Record#:_____

Check One: ( ) Pick Up ( ) Mail ( ) Fax ( ) CD ( ) Talk To [phone/in person] ( ) Secure Email ( ) CIS

Dates of treatment to be released: _____Purpose of Release: _____

This Authorization Expires On (If no date given, 180 days from the date of signature below):_____

Include only: ☐ **All visit records** ☐ **Only selected records below:**

___Discharge Summary	**___Radiology Reports**	**___Immunization Records**
___Outpatient Summaries	**___Laboratory Reports**	**___Operative Notes**
___Other: _____	**_____**	**_____**

☐ **COMPLETE THIS SECTION TO REQUEST YOUR OWN RECORDS OR YOUR CHILD'S RECORDS:**

_____(initials) I hereby request access to my protected health information. I understand that I must complete a new authorization for access to any future psychiatric, behavioral, mental health, HIV, or genetics care. For general medical care for adult patients and patients under the age of 12, this authorization is valid for past and future care. For patients age 12 to 17, the parent must complete a new authorization form, and access by the parent is limited to 30 days and to records prior to the date of the authorization.

☐ **COMPLETE THIS SECTION FOR REQUESTS TO OR FROM ANOTHER PERSON OR PROVIDER:**

I hereby authorize Baystate Health to: ☐ obtain from or ☐ disclose my protected health information to: **(A separate authorization form is required for each release)**

_____

_____

☐ **COMPLETE THIS SECTION FOR RELEASE OF SPECIFIC PRIVILEGED RECORDS. A separate authorization form is required for each release.**

_____ (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 named 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 named 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 named above. I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records. 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 a psychologist or psychotherapist only to the person or organization named above and only for the purpose named above.

_____ **Domestic violence abuse counselor records**	_____ **Social service records**
_____ **Sexual assault counselor records**	_____ **Sexually transmitted disease records**

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that information used or disclosed as a result of this Authorization may be further used or disclosed* by someone who obtains such information and therefore may no longer be protected by federal privacy laws. Except to the extent allowed by law, Baystate Health will not condition treatment on my signing this Authorization. I acknowledge that I have signed this Authorization voluntarily, and these records are released at my request. I also understand that I have the right to revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it. To revoke this Authorization, please complete our Authorization Revocation form and send it to our office at Baystate Health, Health Information Management, 759 Chestnut Street, Springfield, MA 01199.

_____ _____

Signature of patient or patient's representative Date

If patient representative, describe representative's authority or relationship to patient: _____

WE WILL PROVIDE YOU A COPY OF THIS SIGNED FORM