RiverBend MEDICAL GROUP

Authorization For Use or Disclosure of Medical Record Information

Return Completed Forms to:
305 Bicentennial Hwy
Springfield, MA 01118
or fax to 413-782-4047

Medical Record #:

Form Reviewed By:_____

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____
Patient Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Email: _____
Name of Insurance Plan: _____

I hereby Authorize Riverbend Medical Group to:

Please choose one: ○ Release my medical record information to ○ Obtain medical information from

Name/Facility: _____ Attention: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: ○ Personal ○ Referral ○ Legal ○ Insurance ○ Other _____
○ Transfer from Practice/Reason? _____.

Specific Records to be released:

○ Please provide me with a 2 year abstract of my medical records.
○ Please provide me with a copy of my entire medical record.
○ Please provide the specific information as outlined below:

_____ Date(s) of Treatment _____
_____ Date(s) of Treatment _____

COPY FEE: *Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. RiverBend will cap the fee at $25.00 (plus postage) for a two year abstract of your medical record. If you want the entire medical record or more than the two year abstract, the rate will increase proportionatey based on the cost. At no time will the cost-based fees exceed Massachusetts law (MGL Chapter 111; Section 70).*

Authorization to Release Protected Health Information:

STOP **IMPORTANT -** It is extremely important that you select either **YES** or **NO** and **Initial** each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

	Yes	or	No	Initial
> Mental/Behavioral Health records	☐		☐	_____
> HIV/AIDS, including HIV antibody and antigen testing, and HIV/AIDS diagnosis or treatment	☐		☐	_____
> Genetic testing	☐		☐	_____
> Sexually Transmitted Diseases	☐		☐	_____
> Abortion	☐		☐	_____

Term: This Authorization will remain in effect until RiverBend Medical Group (RMG) fulfills this request.
Revocation: I understand that I may revoke this Authorization at any time by requesting it of RMG in writing at the address listed below. The revocation will be effective immediately upon Riverbend Medical Group's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by RiverBend Medical Group in reliance on this Authorization before it received my written notice of revocation. Written Notice is to be mailed to: **Health Information Management Department, 305 Bicentennial Highway, Springfield MA 01118**
Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation, quality or payment for such treatment at RiverBend Medical Group.
Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by RMG.

Sign Here _____ Date _____
Signature of Patient **Date**

Signature of Personal Representative **Authority to act for patient** **Date**

Rev: 05/2016