AUTHORIZATION FOR RELEASE OF INFORMATION

We can honor a request only if this form is filled out completely

Patient Name: ________________________________ DOB:____________ Medical Record #:____________________

Check One: ( ) Pick Up ( ) Mail ( ) Fax ( ) CD ( ) Secure Email ________________________________

I hereby authorize Baystate Health to obtain from or disclose my protected health information to: ____________________________

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Specific dates of treatment: ____

Please check off any of the following if they are to be released:
[ ] Mental Health Records [ ] Sexually Transmitted Disease Records [ ] Drug/Alcohol Treatment Record- Alcohol & Drug Services

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The Specific Information to be disclosed is:

__ Discharge Summary
__ Admission Notes/Mental Status
__ Operative Notes
__ Psychology Testing Reports
__ Immunization Records
__ Outpatient Summaries
__ Laboratory Reports
__ Radiology Reports
__ MRI/Ct Scan Reports
__ EEG, EKG
__ Social Service Records
__ Other, Specify____________

( ) _____ (initials) I hereby request to access my electronic medical records via a computer. I release Baystate Health of any responsibility due to anyone else viewing my medical record while I am accessing my electronic medical record. Viewing of my electronic medical record is valid for medical information that occurred prior to the date of this authorization. Viewing of any subsequent medical information will require a new authorization to be completed.

RELEASE OF HIV/AIDS AND/OR GENETIC INFORMATION (required for each release)

HIV/AIDS

☐ I hereby authorize release of protected health information pertaining to HIV testing and/or diagnosis and/or treatment of Acquired Immune Deficiency Syndrome (AIDS) solely to the person or organization described above and solely for the purpose stated above.

GENETICS

☐ I hereby authorize release of protected health information pertaining to genetic test results to the person or organization described above and solely for the purpose stated above.

____ ____________________
(Signature of Patient or personal representative) *(Date)*

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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, [Provider/Entity Name] will not condition treatment on my signing this Authorization. I acknowledge that I have signed this Authorization voluntarily. 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 leave it with the front desk or send it to our office at Baystate Health, Health Information Management, 759 Chestnut Street, Springfield, MA 01199

If this authorization is for a parent to access their child's record, the access to view their child's medical record (paper or electronic) is limited to 30 days from date of this authorization and to the records noted in this authorization.

This Authorization expires on: ______________________________, (or if unspecified, 180 days from the date of signature.)
[Insert date, time period or event]

____ ____________________
Signature of patient or patient's representative Date

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

I understand that my alcohol and drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my Alcohol and Drug Abuse Records cannot be re-disclosed without my express authorization.

WE WILL PROVIDE YOU A COPY OF THIS SIGNED FORM