NeighborHealth Medical Records
300 Ocean Ave, 4th Floor
Revere, MA 02151

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____

Address: _____

_____

Birth Date: ____ / ____ / ____ Telephone No. _____ MRN _____

I authorize NeighborHealth to release my protected health information to:
Name: _____

Address, fax number, or email address:

_____

PURPOSE OF DISCLOSURE (Please check one):
☐My own use ☐Changing physicians ☐Legal ☐Insurance ☐Other (specify)_____
INFORMATION TO BE RELEASED (Please be specific and include dates of service, date range, and/or provider name(s))
☐Full medical record _____ ☐Clinic notes _____
☐Medication records _____ ☐Laboratory results _____
☐Radiology reports _____ ☐ED records _____
☐Other _____

TO HAVE SPECIALLY PROTECTED CATEGORIES OF INFORMATION INCLUDED, YOU MUST WRITE YOUR INITIALS NEXT TO THE CATEGORY(IES) OF INFORMATION YOU WISH US TO RELEASE AS PART OF THIS REQUEST:
____HIV Testing, Diagnosis, or Treatment Information (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST)
____Commonwealth of Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling
____Alcohol and Drug Abuse Treatment Records protected by the HITECH Act, 42 CFR Part 2
____Records related to Domestic Violence

I understand that I have the right to withdraw my authorization at any time except to the extent that records have already been released. I understand that to withdraw this authorization, I must submit my request to withdraw the authorization in writing to the Director of Medical Records. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and NeighborHealth will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure. *I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no long protected by Federal or State privacy laws; however the recipient may be prohibited from disclosing substance abuse treatment or HIV testing, diagnosis, or treatment information.* I understand that I may inspect or copy the information to be disclosed.
This authorization will remain in effect for **one year (12 months)** from the date signed unless revoked by me. I have carefully read and understand the information above, have had any questions answered, and voluntarily authorize disclosure of the requested information to the specified individual(s) or entity(ies).

Signature of Patient _____ Date: _____

Signature of Legal Representative _____ Relationship to Patient: _____ Date: _____