SIGNATURE MEDICAL GROUP

Correspondence Dept.
680 Centre Street, Brockton, MA 02302
(P) 508-941-7069 | (Fax) 508-941-6202

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. **I hereby authorize**____
Name of Hospital/Physician

____
Street Town/City State Zip

to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient Name:**_______________________________ **Date of Birth:**__________________

Address:____
Street Town/City State Zip

3. **Information to be disclosed to:**______________________________________
Primary Care Physician

SIGNATURE HEALTHCARE CORRESPONDENCE DEPARTMENT
680 CENTRE STREET
BROCKTON, MA 02302

4. **Disclose the following information for treatment dates:**________________to________________

- ☐ Complete Records
- ☐ Abstract
- ☐ Face Sheet
- ☐ Discharge & Summary
- ☐ History & Physical
- ☐ Consult
- ☐ Outpatient Reports
- ☐ X-Ray
- ☐ Laboratory
- ☐ Pathology
- ☐ Physical Therapy
- ☐ Emergency Reports
- ☐ Other Specified______________

____
____

5. **The above information is disclosed for the following purposes:**

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Changing Primary Care Provider

6. **I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.**

7. **This authorization expires (upon)**__________________________(Insert applicable date or event)

_________________________________ _________________________________
8. Signature of Patient or Legal Representative 9. Date

_________________________________ _________________________________
Printed Name of Patient or Legal Representative 10. Relationship to patient or authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ARE COMPLETED

N.B. In certain situations an additional authorization to release sensitive, legally protected information may be required.

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Privileged or Specifically Protected Information

11. Please check YES or NO for each of the following questions:

YES **NO**

☐ ☐ **HIV/AIDS diagnosis and/or treatment:**

I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here to authorize its release_____as required by M.G.L. c111, s70F.

SIGNED:____ ______________________________
(Patient or Legal Representative) (Date)

12. **YES** **NO** **Genetic Testing:**

☐ ☐ I specifically give permission to share information in my record about my genetic testing (excludes therapeutic genetic tests).

Initial here to specifically authorize its release_____as required by M.G.L. c111, s70G. **(We do not disclose genetic information for Insurance Underwriting purposes).**

SIGNED:____ ______________________________
(Patient or Legal Representative) (Date)

Privileged or Specifically Protected Information

13. I understand my medical record contains information relating to the subjects I have checked below and agree to the release of this information. **Please check Yes or No for each of the following if applicable.**

YES	NO	
☐	☐	Alcohol or Drug Abuse Treatment
☐	☐	Psychological Treatment
☐	☐	Rape Victim Counseling
☐	☐	Treatment of Sexually Transmitted Diseases
☐	☐	Abortion
☐	☐	Counseling by a Social Worker
☐	☐	Domestic Violence Counseling

SIGNED:____ ______________________________
(Patient or Legal Representative) (Date)

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