SIGNATURE HEALTHCARE
Brockton Hospital
680 Centre Street
Brockton, MA 02302
(P) 508-941-7000 (Fax) 508-941-6202

UNIT #: _____

REQ #: _____

Authorization Release of Information

A. I hereby Authorize Signature Healthcare Brockton Hospital to release information from the medical record of:

Patient Name: _____ Date of Birth: _____
(First Name) (Middle Initial) (Last Name)

Patient Address: _____Contact Number: _____

B. Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

From / Between (Circle):	**To / Between (Circle):**
Name: _____	Name: _____
Address: _____	Address: _____
FAX Number: _____	**FAX** Number: _____
Telephone Number: _____	Telephone Number: _____

C. Reason for Release of Records:

☐ Treatment ☐ Transfer of Record ☐ Personal Copy ☐ Other _____

A copy service fee will be charged for records that are sent directly to the patient.

D. Information to be released for treatment dates: *from*_____ *to*_____

E. What Records do you wish to obtain copies of?

☐ Signature Healthcare Brockton Hospital Records ☐ Signature Healthcare Primary Care Affiliates Records ☐ Signature Healthcare Women's Health Affiliates Record **Office Location:** _____

F. Documents to be released: (please check the documents you wish to obtain/have released)

Yes	No		Yes	No	
☐	☐	Medical Record Abstract (i.e., History & Physical, Operative/Procedure Reports Clinical / Office Notes, Discharge Summary, All Diagnostic Test Results)	☐	☐	ED Reports
			☐	☐	Radiology Reports
☐	☐	Progress Notes	☐	☐	Laboratory Reports
☐	☐	Discharge Summary	☐	☐	Pathology Reports
☐	☐	Consult Reports	☐	☐	Operative Notes
☐	☐	X-ray Reports	☐	☐	Other_____
☐	☐	Immunization Records	☐	☐	Entire Medical Record

G. Privileged or Specifically Protected Information: Please check Yes or No for each of the following questions.

Yes	No		Yes	No	
☐	☐	Alcohol or Drug Abuse Treatment	☐	☐	HIV/AIDS diagnosis and/or treatment: I specifically give permission to share information. Initial here to specifically authorize its release _____as required by M.G.L., c.111, § 70F.
☐	☐	Sexually Transmitted Diseases			
☐	☐	Domestic Violence Victim's counseling			
☐	☐	Sexual Assault Victim's Counseling			
☐	☐	Communication between patient and Social Worker			
☐	☐	Psychiatric Health – mental health information Including communication between a patient and a Psychiatrist, licensed Psychologist, and Psychiatric Clinical Nurse Specialist	☐	☐	Genetics Testing: I specifically give permission to share information in my record about my genetics testing (excludes Therapeutic genetic tests). Initial here to Specifically authorize its release _____ as required by M.G.L. c.111, 70G. (We do not disclose genetic information For Insurance underwriting purposes.)

G. I understand and agree that:

• **The information which I authorize for release may be re-sent by the recipient and no longer protected by federal privacy regulations** • **I will be charged a fee for information that is sent directly to me** • **I decline the opportunity to inspect or copy the information released** • **I have received a copy of this authorization**	• **I may take back this authorization at any time by notifying the Physician / hospital / clinic / organization from whom I am requesting this information, provided that the information has not already been released** • **This authorization is voluntary** • **My treatment will not be conditioned on the completion of this authorization.** • **My questions about this authorization form have been answered**

H. I understand that this authorization expires 12 months from the date it was signed OR as specified: ___/___/___
If not specified, this authorization will expire 12 months from the date it was received. The authorization may be revoked in writing by me or my Legal representative at any time prior to the expiration date.

X_____ or X_____ and _____ Date: _____
Patient's Signature **Person authorized to sign for patient** **Relationship to patient**