Internal use only

MRN_____

REQ#

CHA Cambridge Health Alliance

Cambridge/Everett/Somerville Hospital 617-381-7126

Authorization for Release of Medical Records

Signed form may be faxed to **617-381-7179**, or
Mail to: **HIM/Medical Records**
CHA Everett Hospital
103 Garland Street
Everett, Ma 02149

Please complete this form and sign on page 2 where indicated

Patient Information:

Patient Name**: Last**_____ **First**_____ **Date of Birth** _____

Home Address: _____ City: _____

State: _____ Zip: _____ Cell Phone: (_____)_____ Other #(_____)_____

I hereby authorize **Cambridge Health Alliance** to release copies of my protected health information to the following person(s) at the address listed below:

Release Information to:

Facility: _____ Address: _____

City: _____ State: _____ Zip: _____

Attention: _____ Phone: (_____)_____ FAX: (_____)_____

Purpose of Disclosure:

❒ Medical Care ❒Insurance ❒ Legal ❒Personal ❒Other:_____

Format of Release:

❒ Paper
❒ Fax (To MD only)
❒ CD

**** Please refer to the Cambridge Health Alliance Privacy Notice for information on copying fees that may be associated with this request. ** There may be additional charges for copies of photographs.***

INFORMATION TO BE RELEASED ***(Please check all that apply and specify dates)*:**

❒ Entire Record _____
❒ Clinic visit notes _____
❒ Discharge Summary _____
❒ Lab Reports _____
❒ Operative Reports _____
❒ Medical Record Abstract *(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)*

❒ Photographs**_____
❒ Pathology Reports _____
❒ X-rays/Scan Reports _____
❒ Other (please specify) _____

If you would like the highly sensitive information included in your records please initial below:

Initial here	HIV/AIDS test results and or treatment.
Initial here	Hepatitis C results and or treatment.
Initial here	Mental Illness, Behavioral Health or Developmental Disability.
Initial here	Substance (i.e. alcohol or drug) Abuse.
Initial here	Sexually transmitted diseases and or HPV results and or treatment.
Initial here	Domestic Violence.
Initial here	Sexual Assault
Initial here	Sensitive OB/GYN treatment and or services.
Initial here	Genetic Testing results and or treatment.
Initial here	Confidential communication with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human

TERM: This Authorization will automatically expire 1 Year from the date signed unless specified:

By my signature below, I hereby authorize Cambridge Health Alliance disclose my health information for the term of this Authorization for the specific purpose(s) listed: ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

I understand that once Cambridge Health Alliance discloses my health information to the recipient, Cambridge Health Alliance cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Cambridge Health Alliance's treatment of me; except, however, if my treatment at Cambridge Health Alliance is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Cambridge Health Alliance may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Cambridge Health Alliance's Privacy Office at the address listed below. The revocation will be effective immediately upon Cambridge Health Alliance's receipt of my written notice, except that the revocation will not have any effect on any action taken by Cambridge Health Alliance in reliance on this Authorization before it received my written notice of revocation.

I may contact **Cambridge Health Alliance's Privacy Officer by mail at 230 Highland Avenue, 6th Floor**, **Somerville, MA 02143** or through the CHA H.I.M. Department.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about disclosing my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Cambridge Health Alliance to disclose my health information in the manner described above.

X _____

Signature of Patient Date/Time

If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signatures:

_____

Signature of Representative Description of Authority Date/Time