Authorization For Use or Disclosure of Medical Record Information

Location Name: ______________________

Reason Code
DWC - Dissatisfied with care
MOA - Moved out of area
INS - Insurance changed
COC - Continuation of Care
PLS - Provider left Steward
IST - Internal Steward Transfer
OTH - Other reason

Patient Information

Patient Full Name: ______________________ Date of Birth: ______________

Patient Address: ______________________ Home Phone: ______________

City: ____________ State ______ Zip: ____________ Work Phone: ______________

Release Information To

I hereby Authorize Steward Health Care Systems to release my medical record information to / obtain information from:

Name/Facility: ______________________ Attention: ______________

Address: ______________________ Phone: ______________

City: ____________ State ______ Zip: ____________ Fax: ______________

Purpose of Request: ◯ Personal ◯ Referral or 2nd Opinion ◯ Legal ◯ Insurance ◯ Other ______________
◯ Transfer from Practice/Reason? ______________________

Information to be Released

◯ Please provide a 2 year abstract of my records -
*An abstract is $25.00 or MA Statute whichever is less

◯ Please provide my entire medical record -
*Full record is $50.00 or MA Statute whichever is less

◯ Other - please be specific, include dates and MD's under comments-
*Note you will be invoiced at the allowable MA Statute rate

Comments

COPY FEE: Pursuant to Chapter 135 of the Acts of 2003, "An Act Establishing Reasonable Fees for Copying Medical Records", Mass. Gen. L. ch. 11, 70, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.

Authorization to Release Protected Information

*__Required__ - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one *Initial each line below to confirm your choices*

- I ☐ DO ☐ DO NOT want **Mental Health or Psychotherapy Notes/Information** released ________
- I ☐ DO ☐ DO NOT want information about ***HIV Tests & Related Information** released ________
- I ☐ DO ☐ DO NOT want information about ***Alcohol and/or Substance Abuse** released ________
- I ☐ DO ☐ DO NOT want information about ***Genetic Testing** released ________
- I ☐ DO ☐ DO NOT want information about **Social Worker Communication** released ________
- I ☐ DO ☐ DO NOT want information about **Rape/Sexual Abuse** released ________
- I ☐ DO ☐ DO NOT want information about **Developmental Disability** released ________
- I ☐ DO ☐ DO NOT want information about **Sexually Transmitted Disease (STD's)** released ________
- I ☐ DO ☐ DO NOT want information about ______________________ released ________

Other sensitive information?

Please confirm that you have put a __checkmark__ and __initialed__ all the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here Date Here

Know Your Privacy Rights Refer to the HIPAA "PRIVACY NOTICE"

____
Patient's Signature **Date***

____
Parent/Legally Recognized Representative Signature** **Date****

Rev. 2/11

*This Authorization is valid for one year unless you specify other wise (enter expiration date)______________________. You may revoke this Authorization at any time by providing a written statement, except to the extent that Steward Health Care Systems has already completed action on it.

*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

** If you are the legally recognized representative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Steward Health Care Systems will not condition treatment on payment of the provision of this Authorization.