Harrington HOSPITAL
Total Local Care

Medical Records Department
100 South Street Southbridge, MA 01550
Phone (508) 765-3085 Fax (508) 765-3147

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____

Address:_____ Phone #:_____

I hereby authorize Harrington Hospital to use, disclose, or obtain the following individually identifiable health information and records as described below.

_____

_____

_____

_____

The following items which may appear in your medical record are privileged or sensitive in nature and must specifically be initialed to authorize use and/or disclosure under Massacusetts State Law:

_____ HIV/AIDS/ARC testing, results, and/or records of treatment

_____ Sexually Transmitted Diseases

_____ Drug and/or alcohol testing results obtained through blood, urine and or other methods

_____ Drug and/or alcohol (substance abuse) treatment records

_____ Abortion

_____ Mental health records and/or information, including psychotherapy notes

_____ Sexual and/or Domestic abuse/assault counseling and/or treatment

_____ Genetic Testing information

Please identify those persons/organizations authorized to use or <u>DISCLOSE</u> your information:

☐ Harrington Hospital ☐ other: _____

Please identify those persons/organizations authorized to <u>RECEIVE</u> your information:

☐ Harrington Hospital ☐ other: _____

Please provide the above requested information for the following use:

☐ Health Care ☐ Legal ☐ Personal use ☐ Other:_____

Photocopy will be deemed as valid as the original Medical Record Number_____

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I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that, if the person or entity receiving the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations or other applicable state or federal laws.

I further understand that the Hospital will not deny me treatment if I refuse to sign this authorization except for research-related treatment or treatment solely related to the creation of the health information to be disclosed, such as a camp/school or employment physical.

If information is requested by my health insurer and I refuse to sign a required authorization, I understand that the health insurer may in certain instances deny payment, enrollment or eligibility for benefits. I understand that I may inspect or request copies of any information disclosed by this authorization as allowed by law.

I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. I further authorize disclosure of my information via the following methods: mail, e-mail, telephone, electronic file, facsimile machine, electronic imaging, written, verbal or as Hospital policy or practice allows.

I hereby release the Hospital, its professionals, employees and agents, from all liability arising from this authorized disclosure of my health information and acknowledge that any and all questions related to this authorization have been explained to me.

This authorization will be deemed valid until the reqest is complete, unless otherwise specified by the patient

or legal representative on: _____
(applicable date or event)

_____ _____
Signature of Patient or Patient's Legal Representative **Date/Time**
(Paperwork attached for legal representative)

_____ _____
Relationship to patient **Date/Time**

Interpreter/Translator:
I am fluent in English and the patient's primary language. I have translated this form to the patient. I have confirmed that any questions the patient has have been relayed and answered by Hospital personnel and conveyed to the patient in his/her primary language.

_____ _____
Interpreter/Translator signature **Date/Time**