Harrington Physician Services
PO Box 40 Southbridge, MA 01550
Phone (508) 765-7977 Fax (508) 909-2113

AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

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

Address:_____ Phone #:_____

I hereby authorize Harrington Physician Services to disclose or obtain the following Health Information:

_____

_____

The following information *which may appear* in your medical record is privileged or sensitive in nature. Massachusetts State Law requires that this information be specifically authorized for use and/or disclosure:

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

_____ Sexually Transmitted Diseases/Infections

_____ Drug and/or alcohol (substance abuse) treatment

_____ Abortion

_____ Genetic Testing information

_____ Mental health information, including psychotherapy notes

_____ Drug and/or alcohol testing results

_____ Sexual or Domestic abuse and assault counseling/treatment

Please identify those persons/organizations you are authorizing to <u>DISCLOSE</u> your information:

☐ Harrington Physician Services – Provider or Specialty Office:_____

☐ Other: _____
Name **City/State/Zip** **Phone #**

Please identify those persons/organizations you are authorizing to <u>RECEIVE</u> your information:

☐ Harrington Physician Services – Provider or Specialty Office:_____

☐ Other: _____
Name **City/State/Zip** **Phone #**

<u>Please provide the above requested information for the following use:</u>

☐ Continuing Health Care ☐ Legal ☐ Personal use ☐ Transfer of Care to a New Provider

☐ Insurance ☐ Other:_____

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 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 policy or practice allows. I understand, unless otherwise revoked or specified, this authorization is valid until the request has been completed.

_____ _____
Signature of Patient or Patient's Legal Representative **Date/Time**