

Authorization for Request of Protected Health Information



Patient Name	Last	First	Middle Initial	Patient Date of Birth (mm/dd/yyyy)
Patient Address	Street	City/Town		State Zip Code
Patient Phone Number				
I hereby authorize and request a copy of my medical records be sent by mail or fax to:				
Outer Cape Health Services P.O. Box 598, Harwich Port, MA 02646 Fax: 508-487-6298				
For the purpose of: <input type="checkbox"/> Personal <input type="checkbox"/> Legal <input type="checkbox"/> Transferring Care <input type="checkbox"/> Other				
Requested Information: _____				<input type="checkbox"/> All Records
Covering the period from: _____ to _____				
Former Practice Information				

Practice Name				

Practice Address				

Phone Number			Fax Number	

Protected under State Law: Please initial below	
Alcohol and/or Drug Abuse Treatment	I DO Authorize. Initial: _____
HIV/Communicable Disease*	I DO Authorize. Initial: _____
Genetic Testing	I DO Authorize. Initial: _____
Mental Health Services	I DO Authorize. Initial: _____
(Mental Health Services by a clinical nurse specialist, Psychologist, Social Worker, counseling professional or a physician specializing in psychiatry licensed under the provision of Title 32)	

To the practice sending records, please send **only** the following:

- Health maintenance sheet
- Immunization record
- Last CPE
- Last 3 office visit notes
- Labs for current and previous year
- All pathology reports
- Last PAP report and any abnormal reports
- Last colonoscopy and any abnormal reports
- Last mammogram and any abnormal reports
- Last chest x-ray and any abnormal reports
- All MRI's, CT's, interventional radiology studies
- All consults in the past 2 years with exception, of all cardiology, oncology, neuropsychiatry and pain consults
- All cardiology testing in the last 2 years
- All neurology testing (EMG, EEG) or pulmonary testing in the past 2 years
- Hospital discharge summaries
- All mental health records for the past 2 years

*A separate release authorization is required for each request to release the results of HIV/AIDS testing, M.G. L. c111§ 70F

**Release of information must comply with the federal HIPAA Privacy Act and federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations. Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

I hereby disclose my health information for the purposed noted above. I understand that once such information has been disclosed to the intended recipient, that OCHS cannot guarantee that the recipient will not re-disclose my health information to a third party. The 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.

If I have questions about disclosure of my health information, I can contact the Outer Cape Health Services Compliance Officer: 508-905-2820 or patientexperience@outercape.org

This authorization is valid for release of Protected Health Information for 180 days from date below **OR** (please indicate):

a one-time disclosure upon termination from services until revoked in writing other

Patient or Legal Representative Name (print) _____

Address: _____

Patient or Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____ Phone Number: _____

A facsimile or copy of this document is valid as the original.
Scan Completed Document to EMR: Consents and Contracts

Revised 10/11/2018