

# Authorization for Request of Protected Health Information



|                             |        |           |                |   |
|-----------------------------|--------|-----------|----------------|---|
| <b>Patient Name</b>         | Last   | First     | Middle Initial | <b>Patient Date of Birth</b> (mm/dd/yyyy) |
| <b>Patient Address</b>      | Street | City/Town |                | State Zip Code                            |
| <b>Patient Phone Number</b> |        |           |                |   |

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:  Personal  Legal  Transferring Care  Other

Requested Information: \_\_\_\_\_  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**

|   |                                |
|---|--------------------------------|
| <b>Alcohol and/or Drug Abuse Treatment</b>  | I DO Authorize. Initial: _____ |
| <b>HIV/Communicable Disease*</b>  | I DO Authorize. Initial: _____ |
| <b>Genetic Testing</b>  | I DO Authorize. Initial: _____ |
| <b>Mental Health Services</b>   | I DO Authorize. Initial: _____ |
| <small>(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)</small> |                                |

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: \_\_\_\_\_

**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](mailto:patientexperience@outercape.org)

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

Revised 2/23/2021