WHITTIER
Rehabilitation Hospital

# Authorization For Use or Disclosure of Medical Record Information

Medical Record #: ____________

☐ 145 Ward Hill Avenue, Bradford, MA 01835
☐ 150 Flanders Road, Westborough, MA 01581
☐ 76 Summer Street, Haverhill, MA 01830

## Patient Information

Patient Name (Please Print): ______________________ Date of Birth: ____________
Patient Address: ______________________ Phone #'s ____________
City: ____________ State ______ Zip: ____________ EMAIL ____________

## I hereby Authorize Whittier Rehabilitation Hospital to:

**Please choose one:** ◯ Release my medical record information to ◯ Obtain medical 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? ______________________.

## Specific Records/Report(s) to be released:

◯ Please provide a 2 year abstract of my records. Reference Massachusetts statute below for current MA state copy fees.
◯ Please provide a copy of my entire record. Reference Massachusetts statute below for current MA state copy fees.
◯ Please provide my specific information as outlined below: Reference Massachusetts statute below for current MA state copy fees.

______________________ Date(s) of Treatment ____________
______________________ Date(s) of Treatment ____________

***COPY FEE:*** *Pursuant to Chapter 135 of the Acts of 2003,"An Act Establishing Reasonable Fees for Copying Medical Records", Mass General Law ch. 111, §70, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.*

## Restricted Authorization to Release Protected Information:

**IMPORTANT -** It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

*Release Records? Check one*

- I ☐ **DO** ☐ **DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation** * released**.**
- I ☐ **DO** ☐ **DO NOT** want **HIV/AIDS Screening Test Results** released
- I ☐ **DO** ☐ **DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released
- I ☐ **DO** ☐ **DO NOT** want **Genetic Testing/Test Results** ** released
- I ☐ **DO** ☐ **DO NOT** want **Confidential Communications with a Social Worker** released
- I ☐ **DO** ☐ **DO NOT** want information about **Rape/Sexual Assult Victim's Counseling** released
- I ☐ **DO** ☐ **DO NOT** want **Child/Elder Abuse or Neglect & & Abuse of an Adult with a Disability** released
- I ☐ **DO** ☐ **DO NOT** want information about **Sexually Transmitted Disease (STD's)** released
- I ☐ **DO** ☐ **DO NOT** want information about **Domestic Violence Victim's Counseling** released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of celveopoing a disease, not test done to diagnose a current contion or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicableto records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here ______________________ Date Here ____________

**Signature of Patient's** **Date**

______________________

**Signature of Personal Representative** **Date** **Relationship to patient or authority to act for patient**

**Term:** This Authorization will remain in effect until Whittier Rehabilitation Hospital fulfills this request.
**Revocation:** I understand that I may revoke this Authorization at any time by requesting it of Whittier in writing at the address listed below. The revocation will be effective immediately upon Whittier's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Whittier Rehabilitation Hospital in reliance on this Authorization before it received my written notice of revocation.
Written Notice is to be mailed to: ADDRESS INSERTED HERE
**Effect on Treatment:** I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Whittier Rehabilitation Hospital.
**Potential for Redisclosure:** I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Whittier.
**Access**: I understand that in certain circumstances Whittier Rehabilitation Hospital has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.