Congenial Healthcare LLC

Authorization For Use or Disclosure of Medical Record Information

Patient Information

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State _____ Zip: _____ Work Phone: _____

Release Information To

I hereby Authorize Congenial Healthcare LLC to release my medical record information to / obtain 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? _____

Information to be Released

○ Please provide a 2 year abstract of my records -
*The fee is $25.00 or MA Statute whichever is less

○ Please provide a 5 year abstract of my records -
*The fee is $50.00 or MA Statute whichever is less

○ Other - more than 5 years - please specify in comments:
*The fee is $ 75.00 or MA Statute whichever is less

Comments

***COPY FEE:** Pursuant to each respective state statute, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Massachusetts Chapter 111, Section 70; Rhode Island Title 23, Chapter 23-1, Section 23-1-48; New Hampshire Chapter 332-I, Section 1*

Authorization to Release Protected Information

Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Release Records? Check one — *Initial each line below to confirm your choices*

I ☐ DO	☐ DO NOT want **Mental Health or Psychotherapy Notes/Information** released	_____
I ☐ DO	☐ DO NOT want information about ***HIV Tests & Related Information** released	_____
I ☐ DO	☐ DO NOT want information about ***Alcohol and/or Substance Abuse** released	_____
I ☐ DO	☐ DO NOT want information about ***Genetic Testing** released	_____
I ☐ DO	☐ DO NOT want information about **Social Worker Communication** released	_____
I ☐ DO	☐ DO NOT want information about **Rape/Sexual Abuse** released	_____
I ☐ DO	☐ DO NOT want information about **Developmental Disability** released	_____
I ☐ DO	☐ DO NOT want information about **Sexually Transmitted Disease (STD's)** released	_____
I ☐ DO	☐ DO NOT want information about _____ released	_____

Other sensitive information?

STOP Please confirm that you have put a checkmark and initialed **all** the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Sign Here _____ Date Here _____

Patient's Signature **Date***

Parent/Legally Recognized Representative Signature** **Date****

Know Your Privacy Rights Refer to the HIPAA "PRIVACY NOTICE"

Rev. 9/13

*This Authorization is valid for one year unless you specify other wise (enter expiration date) _____. You may revoke this Authorization at any time by providing a written statement, except to the extent that Family Medicine North has already completed action on it.

*The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem.

** If you are the legally recognized represenatative of the patient you must provide supporting documentation.

The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. Family Medicine North will not condition treatment on payment of the provision of this Authorization.