GREATER NEW BEDFORD COMMUNITY HEALTH CENTER, INC.
☐ 874 Purchase Street, New Bedford, MA 02740 Telephone (508) 992-6553 / Fax (508)997-2498
☐ 848 Purchase Street, New Bedford, MA 02740 Telephone (508)984-7031 / Fax (508)984-7034
☐ 135 Marion Road, Wareham, MA 02571 Telephone (508)742-3810 / Fax (508)997-2498

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PROTECTED MEDICAL HEALTH INFORMATION

PATIENT NAME: ____________________ **DATE OF BIRTH:** ____________________
GNBCHC CHART #: ____________________ **SS #:** ____________________

I hereby authorize the Greater New Bedford Community Health Center to:

Transfer the following information:

TO: ____________________

Receive the following information:

FROM: ____________________

_____ Progress Notes
_____ Complete Medical Records
_____ Lab Tests
_____ Immunization Record
_____ X-rays and other tests
_____ Other (specify) ____________________

Treatment dates: ____________________

For the purpose of: ☐ Verbal Communication ☐ Legal ☐ Personal ☐Transfer of Care

I understand that my record may contain some highly confidential information. By initialing the lines below, I am specifically authorizing its release.

- _____ Pertaining to the identity, diagnosis or treatment for alcohol and/or drug use.
- _____ Related to sexually transmitted disease.
- _____ Related to AIDS and/or HIV testing, results, counseling or treatment.
- _____ Mental Health screening, diagnosis or treatment.
- _____ Containing information related to rape/sexual abuse.
- _____ Containing information related to abortion, genetic testing or infertility studies.

____________________ (Patient, Parent, Guardian) ____________________ (Date)

This authorization will remain in effect for 1 year after the above date or as specified: ____________________

I understand that I may revoke this authorization at any time by providing the Medical Record Department with a written revocation, and that the revocation will be honored except to the extent that this authorization has been acted upon. I also understand that this information may be redisclosed by the recipient if the recipient is not required to follow privacy regulations or statutes. I understand that my records are protected under federal regulations, specifically 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Federal regulations also prohibit any further re-disclosure of this information by the recipient of my records. I hereby release GNBCHC and all associated staff from all liability or legal responsibilities that may arise from the release of my records.

____________________ (Signature of Patient) ____________________ (Parent, Guardian, Relative)

____________________ (Witness) ____________________ (Relationship)

____________________ (Date) ____________________ (Date)

FOR OFFICE USE ONLY
Format of requested information: ☐ Fax ☐ Paper ☐ Electronic Processed by: ____________________ (Name)
Transfer via: ☐ Pick Up ☐ Mail ☐ Fax Date Processed: