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-DENTAL **1.**

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PROTECTED MEDICAL HEALTH INFORMATION

Patient Name: DOB:

Patient Label	ADDRESS:_____ _____ _____ TELEPHONE NUMBER:_____

PATIENT CONSENT FOR HEALTH INFORMATION EXCHANGE

By agreeing to GIVE CONSENT below, I hereby authorize communication verbally, in writing, or via electronic information exchange to designated party below. Such communication may include requesting, receiving, providing, and using my medical information. I understand that the purpose of communicating about me is to allow the parties to evaluate my needs, provide services to me, and coordinate my care. I further understand that I may be required to sign additional consent forms to be eligible for insurance coverage and payments or certain types of treatments and services. I understand that my medical information will include all pertinent information from my medical record as described here:

● My name and other personal identifying information. ● My identity as an applicant for or recipient of healthcare services, which may include substance use disorder and/or mental health services. ● The contents of my medical record, which may include: –Problems/diagnoses –Visit/discharge/examination assessment and summaries –Laboratory/x-ray tests and results –Medications/immunizations –Procedures –Family/social history –Other information about my health	• My medical record may include information about the following conditions and treatment: –Mental health –Substance use disorder –Sexually Transmitted disease –Pregnancies/abortions –Domestic abuse –Rape/sexual assault –Genetic diseases, testing, and test results –Mammograms –Other information about my health –HIV/AIDS/Testing, Results, Counseling or Treatment

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

TRANSFER THE FOLLOWING INFORMATION:	RECEIVE THE FOLLOWING INFORMATION:
TO: _____ _____ _____	FROM: _____ _____ _____

CHECK INFORMATION REQUESTING:
Treatment Dates: From:_____ To: _____

	Progress Notes		**Complete Med. Records**		**Lab test**		**Immunizations**		**Radiology**		**Other test (list below)**

OTHER:_____

INITIAL_____

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

I understand I have the right to exclude certain types of health information from being exchanged. I exclude the following:_____

I understand that certain federal laws, including the Health Information Portability and Accountability Act 1996 (HIPAA) 45 C.F.R. parts 160 and 164, allow providers and other healthcare organizations to exchange much of my health information without my consent in order to provide me with treatment, receive payment for my care, manage and coordinate my care. I further understand that my healthcare providers are permitted or required by law to provide some of my medical information without my consent to other healthcare providers, public health agencies, and law enforcement for purposes including but not limited to medical emergencies, quality reporting, audits, crimes against persons and property, and certain legal orders. I understand that the Greater New Bedford Community Health Center (GNBCHC) is not responsible for authorized or unauthorized re-disclosure of my health information by receiving providers. I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. (SAMSHA) cannot be disclosed without written consent unless otherwise provided for by the regulations.

Signature of Patient/ Legal Guardian or Authorized Representative:

_____ **Date:**_____

PRINT PATIENT NAME: **DOB:**

I understand that the following healthcare providers, including their staff, employees, and contracted entities, may provide or receive my medical information for the purposes of evaluating my needs, providing services to me, and coordinating my care. I understand that only the providers who need to coordinate a particular aspect of my care will provide or receive information about that aspect of my care.

_____ General Designation: I understand that any of my treating providers may provide or receive my medical information for treatment purposes. I understand that I have a right to obtain, upon request, a list of entities to whom my medical information has been disclosed (List of Disclosures), pursuant to the general designation.

MY CONSENT CHOICE

I understand that I have the right to receive a copy of this consent form.

_____**I GIVE CONSENT.** By my signature below, I acknowledge that I have given my consent as indicated above freely, voluntarily, and without coercion. I understand that I have the right to revoke this consent at any time; however, any information that was already exchanged cannot be taken back. If I have not revoked this consent, it will expire one year after the "Effective Date" of this consent.

_____ **I DENY CONSENT.** By my signature below, I acknowledge that I have denied consent for my healthcare providers to communicate my health information to one another. I acknowledge that by denying my consent, my healthcare providers may have limits on their ability to provide and coordinate my care.

_____

_____ Signature of Patient

Effective Date

_____ _____

Signature of Patient's Legal Guardian or Authorized Representative Effective Date

_____ _____

Print Name of Legal Guardian or Authorized Representative Description of Authority

(If signed by Legal Guardian or Authorized Representative)

_____ _____

Signature of Translator (if applicable) Print name of Translator