New Bedford Community Health
874 Purchase Street New Bedford, MA 02740
Phone: (508)-992-6553
Main Fax: (508)-997-2498
Dental Only Fax: (508)-984-7034

Authorization for Release of Protected Health Information

Please print

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Medical Record Number **(Staff Only):** _____

By signing this Authorization,

I authorize the use or disclosure of my confidential and/or protected health information maintained by ("information from"):

Name: _____ Phone Number: _____

Address: _____

My confidential and/or protected health information may be disclosed under this Authorization to ("information to"):

Name: _____ Phone Number: _____

Address: _____

SCOPE OF USE OR DISCLOSURE:

All health information about me, including my clinical records (notes, labs, immunizations, etc.), including all psychiatric/alcohol or drug use information created or received by the organization, for all dates of service. This does ***not*** include, if applicable, information pertaining to HIV/AIDS, genetic testing, or psychotherapy notes.

Initial here if you are allowing:

_____ Written and verbal **two-way** communication of protected health information between the people/parties listed above.

_____ Written and verbal **one-way** communication of protected health information between the people/parties listed above.

_____ I wish to limit this authorization to specific date(s) of service:

_____

SCOPE OF USE OR DISCLOSURE: INFORMATION WITH ADDITIONAL PROTECTIONS

Initial here if you are allowing:

_____ Information regarding **HIV/AIDS**, including (i) whether the test is ordered or performed and (ii) the results of the test.

_____ Information regarding **genetic testing**.

_____ Information regarding **psychotherapy notes**.

PURPOSE OF THE USE OR DISCLOSURE:

Check off the reason(s) for this Authorization.

_____ Treatment Coordination _____ Transfer of Care

_____ Legal _____ Personal

_____ Other _____

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 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. 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 New Bedford Community Health (NBCH) 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, 42 C.F.R. Part 2, and cannot be disclosed without written consent unless otherwise provided for by the regulations.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under HIPAA and 42 C.F.R. Part 2, and I further acknowledge that I understand those rights. 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 "Date Signed" of this consent.**

Print Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____