AUTHORIZATION FOR RELEASE OR USE OF PROTECTED HEALTH INFORMATION

Family Health Center of Worcester

Please send completed form to:
FHCW Medical Records Department
26 Queen Street, Worcester, MA 01610
Tel: 508-860-7923 | Fax: 508-860-7925
Email: Medicalrecords@fhcw.org

1. PATIENT INFORMATION

Patient First & Last Name: _____

Date of Birth: _____ Medical Record Number: _____ Telephone: _____

Address: _____
Street Apartment

_____
City State Zip

2. RELEASE INFORMATION

I hereby authorize Family Health Center of Worcester to (**SELECT ONE**):
☐ **Send my medical records to** the person/healthcare provider/organization specified below
☐ **Request my medical records from** the person/healthcare provider/organization specified below

Name/Facility: _____

Address: _____
Street Apartment

_____
City State Zip

Telephone: _____ Fax Number: _____

Purpose of Request: ☐ Personal ☐ Continuity of Care ☐ Transfer of Care ☐ Legal ☐ School ☐ Insurance ☐ Other: _____

3. INFORMATION TO BE RELEASED

Date of Services From: _____ to _____

☐ Office Visits ☐ History & Physical ☐ Radiology Reports ☐ Laboratory Reports ☐ Pathology Reports ☐ Consult ☐ Urgent Care
☐ Immunizations ☐ Ultrasound ☐ Abstract (3 years of history, notes, & tests) ☐ Other (specify): _____

4. DELIVERY METHOD

Delivery Method: ☐ In-person pick up ☐ Paper ☐ Fax ☐ Mail ☐ CD (X-ray images only)

Under HIPAA 45CFR,164.524 regulation, Family Health Center of Worcester is permitted to charge a reasonable fee for providing a copy of medical records, which includes costs of printing materials & postage. The medical records copy fee is based on Mass. General Laws ch.111 sec. 70

5. STATUTORILY PROTECTED INFORMATION

My initials below indicate that I permit the following information, if present in my medical records, to be released:

_____ Alcohol & Drug Abuse (42 CFR Part 2 Records) _____ Mental Health _____ Psychotherapy _____ Domestic Violence
_____ Sexually Transmitted Disease (STD) _____ HIV/AIDS _____ Genetic Testing _____ Social Service Notes

6. SIGNATURES

By signing this authorization, I understand that:

- I hereby authorize Family Health Center of Worcester to use or disclose of my individually identifiable protected health information (PHI).
- Information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by federal or state laws on confidentiality.
- I have the right to withdraw (revoke) this authorization at any time, and the revocation must be in writing. The revocation will not apply to health information that has already been released.
- I may refuse to sign this authorization, but my refusal to sign will not affect my ability to obtain treatment or eligibility for benefits.
- This authorization **expires 1 year** from the date of signature on _____

Patient or Legal Representative Signature: _____ Date: _____ Time: _____

Printed Name of Patient or Legal Representative: _____ Relationship to Patient: _____

Note: Legal Representative must provide signed legal documentation to proof your status as authorized representative with access to patient's medical records.

Office Use Only: ID Verified: ☐ Yes ☐ No Date Processed: _____ Staff Initials Who Processed Release: _____