Brockton Neighborhood Health Center

63 Main Street Brockton, MA 02301 Telephone (508) 559-6699 Fax (508) 584-9061

Authorization for Disclosure of Protected Health/Dental Information

Patient Name ____ D.O.B. _______________

Address ____

Telephone # ____

(Please include complete name, address, and telephone #)

I understand that information used or disclosed pursuant to this authorization could be subject to **redisclosure** by the recipient and, if so, may be subject to federal or state law protecting its confidentiality.

Release information *TO:* ____

(Facility Name)

____

(Street Address)

____

(City, State, Zip Code)

Release information *FROM:* ____

(Facility Name)

____

(Street Address)

____

(City, State, Zip Code)

Purpose of Release:

☐ Transferring Care ☐ Legal ☐ Insurance ☐ Personal ☐ School/Camp ☐ Specialist Medical Provider/Hospital ☐ Dental

Release the Following Information

☐ Last Physical Exam_______
☐ Immunizations________
☐ OB/GYN Records_______
☐ Labs_______

☐ Complete Dental Record_______
☐ Dental X-Ray________
☐ X-Ray Reports__________
☐ Other ________________________

☐ Entire Records_________
Entire Record ONLY Includes: Office Notes, Radiology, Labs, Immunizations, Consultations, and Telephone calls. WILL NOT include protected or privileged information.

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Protected Information

To request the release of protected or privileged information you **MUST** check **AND** initial each item that you want released below. If this area is not complete your entire record request will not include protected information**.**

I ☐ DO want information about HIV Testing and related information released _______
I ☐ DO want information about Sexually Transmitted Disease released _______
I ☐ DO want information about Sexual Abuse released _______
I ☐ DO want information about Mental Health/Psychiatric Treatment released _______
I ☐ DO want information about Abortion (past or present) released _______
I ☐ DO want information about Substance Abuse released _______
I ☐ DO want information about Other: ______________________released _______

This authorization for release of confidential information (unless revoked earlier) expires sixty (60) days from the date signed by the patient or authorized agent.
I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.

I have read, or have had read to me, and fully understand the above statements as they apply to me. I knowingly consent to disclosure of those portions of my medical record information for the purpose or the need as stated above. I further understand that I may revoke this consent at any time except when disclosure has already been made. I also understand I may not revoke this authorization if it relates to an order of the court.

Signature (18 years or older): ____ Date: _____________

Witness: ____ Date: ______________

Medical Records Staff Initials __________________ Date Sent __________

(Revised 07/16)