Authorization for Request of Protected Health Information

Outer Cape HEALTH SERVICES

Patient Name Last	First	Middle Initial	**Patient Date of Birth** (mm/dd/yyyy)

Patient Address Street	City/Town	State	Zip Code

Patient Phone Number

I hereby authorize and request a copy of my medical records be sent by mail or fax to:

Outer Cape Health Services
P.O. Box 598, Harwich Port, MA 02646
Fax: 508-487-6298

For the purpose of: ☐ Personal ☐ Legal ☐ Transferring Care ☐ Other

Requested Information:_____ ❑ All Records

Covering the period from:_____to _____

Former Practice Information

_____
Practice Name

_____
Practice Address

_____
Phone Number Fax Number

Protected under State Law: Please initial below	
Alcohol and/or Drug Abuse Treatment	I DO Authorize. Initial:
HIV/Communicable Disease*	I DO Authorize. Initial:
Genetic Testing	I DO Authorize. Initial:
Mental Health Services	I DO Authorize. Initial:
(Mental Health Services by a clinical nurse specialist, Psychologist, Social Worker, counseling professional or a physician specializing in psychiatry licensed under the provision of Title 32)	

*A separate release authorization is required for each request to release the results of HIV/AIDS testing, M.G. L. c111§ 70F

**Release of information must comply with the federal HIPAA Privacy Act and federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations. Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

I hereby disclose my health information for the purposed noted above. I understand that once such information has been disclosed to the intended recipient, that OCHS cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

If I have questions about disclosure of my health information, I can contact the Outer Cape Health Services Compliance Officer: 508-905-2820 or patientexperience@outercape.org

This authorization is valid for release of Protected Health Information for 180 days from date below **OR** (please indicate):

❑ a one-time disclosure ❑ upon termination from services ❑ until revoked in writing ❑ other

Patient or Legal Representative Name (print) _____

Address: _____

Patient or Legal Representative Signature:_____ Date: _____

Relationship to Patient:_____ Phone Number: _____

A facsimile or copy of this document is valid as the original.
Scan Completed Document to EMR: Consents and Contracts

Revised 10/11/2018