South Cove Community Health Center
145 South Street
Boston, MA 02111
T: 617-457-6617 Fax: 617-457-6600 Email: medical.records@scchc.org

Date: _____ **Regarding: Medical Record Disclosure**

Patient Name: _____

DOB: _____

To: _____

_____

_____

We have received your request for Disclosure of Health Information for the patient named above. Your request is being returned for the following reason(s):

☐	The Authorization is not compliant under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
☐	Medical information is confidential and may be released only upon written consent of the patient. If the patient is a minor or incapacitated, the parent(s) or legal guardian may sign.
☐	The medical record contains information protected by a specific statute or regulation. Specific authorization from the patient or legally recognized representative is required to release the information.
☐	A copy of our authorization form is enclosed. Please complete and return to the address below.
☐	We are unable to identify the person listed above based on the information provided.
☐	The signature on the Authorization to Disclose does not match the signature on our file. We do not accept electronic signatures.
☐	Please provide specific dates of services for the information requested.
☐	Our system does not show that services were rendered at SCCHC for the person listed above.
☐	Please provide the following additional document(s) ☐ Copy of Health Care Power of Attorney ☐ Copy of Death Certificate ☐ Letter of Representation
☐	Massachusetts' statutes require the health center to maintain records for 20 years after the last visit. The records you have requested exceed the retention statute.
☐	There is a $_____ fee payable in advance to process this request. The payment has not been received.
☐	Our record indicates that the previously requested information has not been received.
☐	Our record indicates that the requested information has been previously faxed/mailed on _____.
☐	Other:

Please mail any requested information to:

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