



South Cove Community Health Center

**145 South Street
Boston, MA 02111**

T: 617-457-6617 Fax: 617-457-6600 Email: medical.records@sechc.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):

<input type="checkbox"/>	The Authorization is not compliant under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
<input type="checkbox"/>	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.
<input type="checkbox"/>	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.
<input type="checkbox"/>	A copy of our authorization form is enclosed. Please complete and return to the address below.
<input type="checkbox"/>	We are unable to identify the person listed above based on the information provided.
<input type="checkbox"/>	The signature on the Authorization to Disclose does not match the signature on our file. We do not accept electronic signatures.
<input type="checkbox"/>	Please provide specific dates of services for the information requested.
<input type="checkbox"/>	Our system does not show that services were rendered at SCCHC for the person listed above.
<input type="checkbox"/>	Please provide the following additional document(s) <input type="checkbox"/> Copy of Health Care Power of Attorney <input type="checkbox"/> Copy of Death Certificate <input type="checkbox"/> Letter of Representation
<input type="checkbox"/>	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.
<input type="checkbox"/>	There is a \$_____ fee payable in advance to process this request. The payment has not been received.
<input type="checkbox"/>	Our record indicates that the previously requested information has not been received.
<input type="checkbox"/>	Our record indicates that the requested information has been previously faxed/mailed on _____.
<input type="checkbox"/>	Other:

Please mail any requested information to:

**South Cove Community Health Center
Medical Records Department
145 South Street
Boston MA 02111**

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