South Cove Community Health Center Request to Obtain Health Record Information from Other Health Care Provider

Instructions: Patient: Please complete, sign, and send this form to the Health Care Provider. Health Care Provider: Please Fax or Mail requested information (paper, disc, or USB) to address belo

If not entire record, please check each item to be released:	Patient Name (First, M	liddle, Last)]	Date of Birth	
I authorize the Health Care Provider listed below to release my medical record information to: South Cove Community Health Center 145 South Street Boston MA 02111 Phone: 617-457-6617 Fax: 617-457-6600 Health Care/Provider Name Address Telephone # City/State/Zip Code Fax # Information to be Disclosed: Latest Two Years or Office Notes Immunization Records Office Notes Immunization Records Office Notes Immunization be excluded from this release: HUXIDS Testing Security Code Do not disclose IDo not disclose Parpose/Use Of The Requested Information: Patient has an appointment at SCCHC: Intervisition with Reprist is first abvor. Inderstand that the revocation, true do so in writing a writing approximation with not apply to infor has an appointment at SCCHC: Inderstand that In twa a right to revoke this authorization. </th <th>Address</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>	Address						
South Cove Community Health Center 145 South Street Boston MA 02111 Phone: 617-457-6617 Fax: 617-457-6600 Health Care/Provider Name Address City/State/Zip Code Information to be Disclosed: Latest Two Years or Special Records, I can be beek each item to be released: Office Notes Immunization Records Bost Records, I can requesting that the following information be excluded from this release: HV/AIDS Testing Sexually Transmitted Disease Do not disclose Do not disclose Propose/Use Of The Requested Information: appointment at SCCHC: Prove/Use Of The Requested Information: appointment at SCCHC: Inderstand that I have a right to revoke this authorization at any time and if I revoke this authorization. I most do so in writing a provider at the address listed above. I understand that the revocation will not apply to inform has already been released in response to this authorization at any time and if I revoke this authorization. I most do so in writing a field to are browe to this authorization. I understand that the revocation will not apply to information as already been released in response to	City/State/Zip Code					Telephone #	
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Fax: 617-457-6600 Health Care/Provider Name Address Telephone # City/State/Zip Code Fax # Information to be Disclosed: □Latest Two Years or □Specific Dates: /							
Health Care/Provider Name Address Telephone # City/State/Zip Code Fax # Information to be Disclosed:							
City/State/Zip Code Fax # Information to be Disclosed:	Health Care/Provider	Name	Fax: 617	-457-660()		
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Information to be Disclosed: □Latest Two Years or □Specific Dates: / to // or □Entire If not entire record, please check each item to be released:	Address			Telephon	e #		
□Latest Two Years or □Specific Dates:/	City/State/Zip Code			Fax #			
If not entire record, please check each item to be released: Immunization Records Medication Records Dental X-Ra Office Notes Immunization Records Other: Dental X-Ra Most Recent Phys. Exam Lab Reports Other: Special Records: I am requesting that the following information be excluded from this release: HIV/AIDS Testing Sexually Transmitted Disease Psychiatric Care/Treatment Genetic Tess Do not disclose Do not disclose Do not disclose Do not disclose Do not disclose Do not disclose Do not disclose Do not disclose Purpose/Use Of The Requested Information: Infertility Testing Medical Treatment ITransfer of Care Other: Purpose/Use Of The Requested Information: Sex (HIPAA Compliant Fax: 617-457-6600) Patient has an appointment at SCCHC: Image of the revocation will not apply to inform has already been released in response to this authorization at any time and if I revoke this authorization, I must do so in writing a written revocation will not apply to inform has already been released in response to this authorization. I understand that the revocation will not apply to inform has already been released in response to this authorization. I understand that the revocation will not apply to my insurance compa law provides my insure with the right to contest a claim under my policy. This authorization will expire automatically in six months from the date on which it was signed	Information to be Dis	sclosed:					
□Office Notes □Immunization Records □Medication Records □Dental X-Ra □Most Recent Phys. Exam □Lab Reports □Other:	□Latest Two Years	or	ates: /	_ <u>/</u> t	o <u>/</u>	/ o	r 🛛 Entire Reco
□Most Recent Phys. Exam □Lab Reports □Other:	If not entire record, p	lease check each item to be rele	eased:				
Special Records: I am requesting that the following information be excluded from this release: HIV/AIDS Testing Sexually Transmitted Disease Psychiatric Care/Treatment Genetic Tes Do not disclose Do not disclose Do not disclose Do not disclose Abortion Alcohol and Drug Abuse Infertility Testing Do not disclose Do not disclose Do not disclose Do not disclose Do not disclose Purpose/Use Of The Requested Information:			n Records				□Dental X-Rays
HIV/AIDS Testing Sexually Transmitted Disease Psychiatric Care/Treatment Genetic Test □Do not disclose Abortion Alcohol and Drug Abuse Infertility Testing □Do not disclose □Do not disclose □Do not disclose □Do not disclose □Do not disclose □Do not disclose □Do not disclose Purpose/Use Of The Requested Information: □ □ Patient fast an appointment at SCCHC: □ □Delivery Method: □Mail □Fax (HIPAA Compliant Fax: 617-457-6600) Patient has an appointment at SCCHC: □ 1. I understand that I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing at written revocation to the Health Care Provider at the address listed above. I understand that the revocation will not apply to inform has already been released in response to this authorization. I understand that the revocation will not apply to my insurance compa law provides my insurer with the right to contest a claim under my policy. 2. This authorization will expire automatically in six months from the date on which it was signed or as specified:	-		<u> </u>				
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Abortion Alcohol and Drug Abuse Infertility Testing □Do not disclose □Do not disclose □Do not disclose Purpose/Use Of The Requested Information: □Medical Treatment □Transfer of Care □Other:		· · · · · ·	ted Disease			atment	-
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Delivery Method: □Mail □Fax (HIPAA Compliant Fax: 617-457-6600) Patient has an appointment at SCCHC: 1. I understand that I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing at written revocation to the Health Care Provider at the address listed above. I understand that the revocation will not apply to inform has already been released in response to this authorization. I understand that the revocation will not apply to my insurance compare law provides my insurer with the right to contest a claim under my policy. 2. This authorization will expire automatically in six months from the date on which it was signed or as specified:/ 3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be prederal privacy laws or regulations. 4. I understand authorizing the disclosure of information identified above is voluntary. I need not sign this form to ensure health care	Purpose/Use Of The !	Requested Information:					
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Relationship Of Personal Representative To Patient If Signed By Someone Other Than Patient, Please State Reason, Attach Docu							