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 below.

(1)

Patient Name (First, Middle, Last)	Date of Birth
Address	
City/State/Zip Code	Telephone #

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

(2)

Health Care/Provider Name	
Address	Telephone #
City/State/Zip Code	Fax #

(3)

Information to be Disclosed:

☐Latest Two Years or ☐Specific Dates:_____/_____/_____ to _____/_____/_____ or ☐Entire Record

If not entire record, please check each item to be released:

☐Office Notes ☐Immunization Records ☐Medication Records ☐Dental X-Rays
☐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 Testing
☐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	

(4)

Purpose/Use Of The Requested Information:

☐Medical Treatment ☐Transfer of Care ☐Other: _____

(5)

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 and present my written revocation to the Health Care Provider at the address listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the 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 protected by federal 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 treatment.

(6)

Signature Of Patient or Personal Representative	Print Name	Today's Date
Relationship Of Personal Representative To Patient	If Signed By Someone Other Than Patient, Please State Reason, Attach Documentation.	