



## 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)	<b>Information to be Disclosed:</b>			
<input type="checkbox"/> Latest Two Years or <input type="checkbox"/> Specific Dates: ____/____/____ to ____/____/____ or <input type="checkbox"/> Entire Record				
<b>If not entire record, please check each item to be released:</b>				
<input type="checkbox"/> Office Notes <input type="checkbox"/> Immunization Records <input type="checkbox"/> Medication Records <input type="checkbox"/> Dental X-Rays				
<input type="checkbox"/> Most Recent Phys. Exam <input type="checkbox"/> Lab Reports <input type="checkbox"/> Other: _____				
<b>Special Records:</b> I am requesting that the following information be <b>excluded</b> from this release:				
<u>HIV/AIDS Testing</u> <u>Sexually Transmitted Disease</u> <u>Psychiatric Care/Treatment</u> <u>Genetic Testing</u>				
<input type="checkbox"/> Do not disclose <input type="checkbox"/> Do not disclose <input type="checkbox"/> Do not disclose <input type="checkbox"/> Do not disclose				
<u>Abortion</u> <u>Alcohol and Drug Abuse</u> <u>Infertility Testing</u>				
<input type="checkbox"/> Do not disclose <input type="checkbox"/> Do not disclose <input type="checkbox"/> Do not disclose				

(4)	<b>Purpose/Use Of The Requested Information:</b>		
<input type="checkbox"/> Medical Treatment <input type="checkbox"/> Transfer of Care <input type="checkbox"/> Other: _____			

(5)	<b>Delivery Method:</b> <input type="checkbox"/> Mail <input type="checkbox"/> Fax (HIPAA Compliant Fax: 617-457-6600)	Patient has an appointment at SCCHC: _____
-----	--	--

- 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.
- This authorization will expire automatically in **six months** from the date on which it was signed or as specified: \_\_\_\_/\_\_\_\_/\_\_\_\_.
- 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.
- 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.	