South Cove Community Health Center
Request to Disclose Health Record Information

Instruction: Please complete, sign (No electronic signature), and return this form to: Fax: 617-457-6600, Email: medical.records@scchc.org.
or Mail to: South Cove CHC – Medical Records, 145 South Street, Boston, MA 02111. We will notify you if charges are applicable.

(1)

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

(2)

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: _____

(3)

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)

Information To Be Provided To (Name of Person or Institution):	Relationship:
Address:	Email:
City/State/Zip Code:	Telephone #:

(5)

Purpose/Use Of The Request Information:	Fax #:
☐Personal Use ☐Insurance ☐Transfer of Care	
☐Medical Treatment ☐Legal ☐Other: _____	

(6)

Delivery Method: ☐Mail ☐ Email ☐Fax	☐Oral/Telephone ☐Pick up at: _____	**Media Type:** ☐Paper ☐USB

1. I understand that South Cove Community Health Center may charge a fee related to disclosing my health information records.
2. 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 Center 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.
3. This authorization will expire automatically in **six months** from the date on which it was signed or as specified: _____/_____/_____.
4. 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.
5. I understand authorizing the disclosure of information identified above is voluntary. I need not sign this form to ensure health care treatment.

(7)

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 reasons, attach documentation.	

SCCHC Use Only **Charges (If applicable)**

Base Fee: $25 USB Media Fee: $6.50
Copying Fee (Total Pages _____): ($1.00/first 100 pages/51 cents/each additional) Total Fee: $_____
Make checks payable to: South Cove Community Health Center

Information was disclosed on: _____/_____/_____ by (Staff Name)

If personally disclosed: Type of Photo ID: _____ ID #: _____ Signature: _____