HOPEDALE
CARDIOVASCULAR
ASSOCIATES

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

PATIENT INFORMATION

Patient Name: Patient Date of Birth:

Patient Address: Street: Apt #:

City: State:

Zip:

Telephone Contact #: Day: Evening:

E-Mail Address:

Physician/Office providing the information:

Persons(s)/Organization receiving the information **(please provide complete mailing address):**

PURPOSE

(Please check the appropriate box)

- o I am receiving treatment by a specialist
- o Insurance
- o Legal Matter
- o Personal
- o School
- o I am transferring my care to another healthcare provider

May we ask why you are leaving?:

- o Moving
- o Change of insurance
- o Dissatisfied (please explain)

- o Other

INFORMATION TO BE RELEASED

There is NO charge for:

- Patient summary, immunization record, most recent physical and labs

There IS a charge for:

- Laboratory, X-ray or other Diagnostic Testing for Date(s) of Service:___________________
- Office Notes or Date(s) of Service: ____
- Medical Record – Unless specified, only the last three years of the record will be sent.

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

O Yes O No HIV/AIDS diagnosis and treatment.

O Yes O No Genetic test results and records relation to any genetic condition.

O Yes O No Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFROMATION UNLESS FURTHER DISCLOSURE IS EXPRESSIVELY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or warning request.

O Yes O No Other(s): Please list details of Mental Health Diagnosis and or/ Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (*I understand that my permission may not be required to release my mental health records for payment purposes)*

O Yes O No Confidential Communications with a Licensed Social Worker

O Yes O No Details of Domestic Violence Victims' Counseling

O Yes O No Details of Sexual Assault Counseling

O Yes O No Details of Sexually Transmitted Disease

Incomplete forms will be returned and could delay your request.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
    - to the extent that action has been taken in reliance on this authorization
    - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Hopedale Cardiovascular Associates.
- I understand that this authorization will automatically expire in 12 months unless otherwise specified:

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records, of, my condition to those persons or agencies listed above.

Patient's Signature: ______________________________ **Date:** ______________

Signature of Legal Representative: ______________________ **Date:** ______________

Print Name: ______________________ **Relationship of representative to patient:** ______________