Health Information Management Services

ACTION CHC 130 Water Street, Fitchburg, MA 01420 Fitchburg CHC 326 Nichols Rd, Fitchburg, MA 01420
Gardner CHC 175 Connors Street, Gardner, MA 01440 Leominster CHC 14 Manning Ave, Leominster, 01453
Leominster CHC 165 Mill Street, Leominster, MA 01453 | 978-878-8100 | www.chcfhc.org

Authorization for Disclosure of Protected Health Information (PHI)

This form is for the purpose of disclosures made through communication, access, or other uses of Protected Health Information (PHI). If a copy of medical record(s) is needed refer to the Community Health Connections (CHC) "*Authorization for the Release of Medical Information*" form. Note: patient portal access does not require authorization.

Date of request: ____________________________

I, (print name)_________________________________ DOB _________________, authorize the disclosure of health information about me as described below.

1. CHC is authorized to use/disclose my health information for healthcare provided to me at the CHC site:
   □ ACTION □ Fitchburg □ Gardner □ Leominster
2. I authorize CHC to release my health information to the following:
   □ spouse □ family member:___________________ □ other;___________________________________

   Complete Name and address of person(s): ____
   ____
3. Information that may be used/disclosed:
   □ communication (in person/phone) □other:____

   Describe:____
4. The information will be used/disclosed for the following purpose(s):____
   ____
5. I understand that if the person or medical affiliate that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
6. I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on this matter.
7. This authorization **expires** on:
   (date) ________________, or
   □ one year from the date of this authorization, or
   □ indefinite.

Patient Signature:____ Date:____________________

Witness Signature:____ Date:____________________

Personal Representative (if applicable):____________________________ Date:____________________