Community Health Connections
We take great care of you!

175 Connors St, Gardner, MA 01440
Phone: (978) 878-8100
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Health Information Management Services

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Please note this record release is for CHC Patient records only. It does not include CHC Dental or Behavioral health records. Please see the individual departments for release of those records.

Patient Name: _____ Date of Birth: _____

Address: _____ Phone#: _____

I authorize Community Health Connections, Inc. to: ☐ Request protected health information from
☐ Release protected health information to

Name/Facility: _____ Phone #: _____

Address: _____ Fax #: _____

Dates of service to include: from ___/___/___ to ___/___/___

Information to be released:
☐ Entire record ☐ Date of service ___/___/___ ☐ Medication list ☐ Lab results ☐ Problem list
☐ X-rays ☐ Immunization record ☐ Last physical exam

In compliance with Federal and State Regulations, certain health information needs specific authorization to disclose. Initial below to authorize disclosure of this information.

_____ Substance Abuse (Drug/Alcohol) Treatment (42 CFR Part 2)
_____ HIV/AIDS Results/Treatment (MGL 111 70(F)) _____ Genetic Testing (MGL 111 70(G))

The purpose of this release:
☐ Transfer of care ☐ Coordination of care ☐ Legal ☐ Insurance ☐ School ☐ Personal use
☐ Pre-employment ☐ Other (specify) _____

This authorization expires in 1 year from the date signed unless otherwise specified _____

I understand that:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I may inspect or copy information to be disclosed as provided in the Notice of Information. I understand that arrangements can be made to inspect my medical or billing record on-site, by contacting the Medical Records Department at the address listed above.
- There will be a fee for copying my health information. **A charge will be made of twenty-five cents (0.25) per page for a copy of the medial record on paper or five dollars ($5.00) per CD.**
- Any authorized disclosure carries the potential for future unauthorized re-disclosure. CHC is not responsible for any re-disclosure of this information by those persons/organizations that this authorized release of records governs.
- I have the right to revoke the authorization at any time by presenting a written request to Medical Records at the address above. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

_____ _____ _____
Patient/Guardian/Legal Representative Signature Patient Date of Birth Date

_____ _____
Patient/Guardian/Legal Representative Printed Name Relationship to Patient