AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Lowell General Hospital

MRN# ______________________

Please complete in ink

Patient's Name: ____
Last First Middle

Home Address: ____

____

Home Telephone: ______________________ Date of Birth: ______________________

RECIPIENT: Name of person or class of persons to whom Lowell General Hospital may disclose my health information: ____

Address: ____

Email Address: ____

TREATMENT DATES: ____

INFORMATION TO BE DISCLOSED (check all that apply):

- ☐ Discharge Summary
- ☐ Emergency Room
- ☐ History and Physical
- ☐ Other *(please specify)* ____
- ☐ Laboratory Results
- ☐ Operative/Procedure Report
- ☐ Radiology Reports

PLEASE CHECK THE FORMAT YOU PREFER TO RECEIVE YOUR MEDICAL RECORDS: ☐**PAPER** ☐**ELECTRONIC**

****NOTE: Sending your medical records through email is not a secure method and may put your medical records and personal Information at risk.**

PURPOSE OF DISCLOSURE **(Please check one):**

☐Medical Care ☐Legal Matters ☐Insurance ☐Personal ☐Other (specify):______________________

MY CONFIDENTIAL INFORMATION:

I acknowledge, and hereby specifically authorize the use and/or disclosure by checking any of the boxes next to a category of confidential information listed below:

- ☐ Alcohol/drug abuse treatment information (protected by Federal Confidentiality Rules 42 CFR Part 2)
- ☐ Psychiatric Records
- ☐ HIV/AIDS test results
- ☐ Domestic abuse
- ☐ Sexual abuse
- ☐ Abortion
- ☐ Sexually Transmitted Diseases
- ☐ Genetic Testing
- ☐ Other: ____

TERM: This Authorization will remain in effect:

☐ From the date of this Authorization until __________________ ____, 20___

☐ Until Lowell General fulfills this request

If I fail to specify an expiration date this authorization will expire one year from my signature date.

I understand that once Lowell General Hospital discloses my health information to the recipient, Lowell General Hospital cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. However, if my information includes alcohol or drug abuse treatment program records or information, the confidentiality of the records or information is protected by federal law (42 C.F.R. Part 2) that prohibits re-disclosure except with my specific written consent.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at Lowell General Hospital. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Health Information Management Department at 295 Varnum Avenue, Lowell, MA 01854. The revocation will be effective immediately upon the Hospital receipt of my written notice, except that the revocation will not have any effect on any action taken by the Hospital in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily, authorize Lowell General Hospital to use or disclose my health information in the manner described above.

_______________________________________ _____________________________

Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____________________________ _______________________ ________________

Signature of Authorized Personal Representative Relationship to Patient Date

PLEASE COMPLETE ALL AREAS ON THIS FORM. BLANK AREAS WILL REQUIRE THIS FORM TO BE RETURNED FOR COMPLETION.
THANK YOU.

Return To: **Health Information Management Department**
Release of Information
Lowell General Hospital **Phone: 978-937-6327**
295 Varnum Avenue **Fax: 978-937-6869**
Lowell, MA 01854