



THE CAMBRIDGE HEALTH ALLIANCE
AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

[X] Request for Copies of Medical Records [] Request to Review Medical Records

Medical Record # _____

Patient Name: _____

Home Address: Last First Middle _____

City: _____ State: _____ ZIP: _____

Home Telephone: _____ Date of Birth: _____

I authorize Cambridge Health Alliance to: [X] Obtain from [] Disclose to [] Communicate with

Name/Facility: _____

Address: _____

State: _____ ZIP: _____ Phone: _____ Fax: _____

Attention: _____

Disclose the following information for treatment dates: ALL DATES OF TREATMENT/CARE _____

- [X] Entire Medical Record OR
[] Face Sheet [] Admission Note [] History & Physical [] Progress Notes
[] Consults [] Lab Reports [] Pathology Reports [] X-ray/Scan/Imaging Reports
[] Operative Reports [] Emergency Reports [] Physical Therapy Notes [] Clinic Notes
[] Medication Notes [] Treatment Plan [] Discharge Summary
[] Abstract (Discharge Summary, History & Physical, Operative, Pathology & Test Reports)
[] Other _____

The purpose of this disclosure is: [X] Medical Care [] Legal Matter [] Insurance [] Personal
[] Other _____

TERM: This Authorization expires /terminates/ends:

[X] 90 days from the date signed [] On Other date, reason or event _____

By my signature below, I hereby authorize Cambridge Health Alliance to obtain, use and/or disclose my health information for the term of this Authorization for the specific purpose(s) listed: ("At the request of the patient" is sufficient if the patient is initiating this Authorization).

I understand that once Cambridge Health Alliance discloses my health information to the recipient, Cambridge Health Alliance cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

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 Cambridge Health Alliance's treatment of me; except, however, if my treatment at Cambridge Health Alliance is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Cambridge Health Alliance may refuse to treat me if I do not sign this Authorization.

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 Cambridge Health Alliance's Privacy Office at the address listed below. The revocation will be effective immediately upon Cambridge Health Alliance's receipt of my written notice, except that the revocation will not have any effect on any action taken by Cambridge Health Alliance in reliance on this Authorization before it received my written notice of revocation.

I may contact Cambridge Health Alliance's Privacy Officer by mail at 432 Columbia St. Suite 15/16C Cambridge, MA 02141 or



through any of CHA hospital's H.I.M. Departments (listed at the bottom of the page).

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily, authorize Cambridge Health Alliance to obtain, use and/or disclose my health information in the manner described above.

X

Signature of Patient

Date

If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signatures:

Signature of Personal Representative

Description of Authority

Date

MY HIGHLY CONFIDENTIAL INFORMATION

By signing my name next to a category of highly confidential information listed below, I specifically authorize obtaining, using and/or disclosing the type of highly confidential information indicated next to my signature, if any such information will be obtained, used or disclosed pursuant to this Authorization.

- Information about a Mental Illness, Behavioral Health or Developmental Disability
Information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
Information about HIV/AIDS Testing, Status or Treatment
Information about Venereal Disease(s) Status or Treatment
Information about Substance (i.e., alcohol or drug) Abuse Status or Treatment
Information about Abuse of an Adult with a Disability
Information about Sexual Assault
Information about Child Abuse and Neglect
Information about Genetic Testing
Information about abortion
Information about mammography
Information about family planning services
Information related to mental health community program records
Information about research involving controlled substances
Information about domestic violence
If I am an emancipated minor, information about treatment and diagnosis (except to my parents)

DATE:

Table with 3 columns: The Cambridge Hospital, Somerville Hospital, Whidden Memorial Hospital. Each column lists address, HIM Department, and Release of Information Section contact info.

Where to send the medical record:

Please send this record to the Cambridge Health Alliance site where you plan to receive your care. For a full listing of CHA locations, and addresses, please visit www.challiance.org or call us at 617-665-1305.

Can I send the form to you to send to my doctor?

Absolutely! In fact we will enter the your name as well as your mailing address and send updates as they come available as well as track receipt of the patient's medical record.

Can I make an appointment before I you receive my medical record?

Yes – call (781) 338-0500 to make your appointment today!

Do I need to have my record at the time I see my doctor?

To continue the care you are current receiving, your doctor would like to have your record at the time you arrive. Please allow 3 to 4 weeks from when you mail your records to when we receive the copy.