



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 _____
(including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- 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: _____

<p>The Cambridge Hospital 1493 Cambridge Street Cambridge, MA 02139</p> <p>HIM Department Release of Information Section 617-665-1058</p>	<p>Somerville Hospital 230 Highland Avenue Somerville, MA 02143</p> <p>HIM Department Release of Information Section 617-591-4127</p>	<p>Whidden Memorial Hospital 103 Garland St. Everett, MA 02149</p> <p>HIM Department Release of Information Section 617-381-7127</p>
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Where to send the medical record:

Cambridge Health Alliance
Family Medicine Center, HIM Department
195 Canal Street, Malden MA 02148
(781) 338-0500

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.