CHA Cambridge Health Alliance

Internal Use Only
MRN _____

Authorization to Communicate Protected Health Information and Obtain PHI from other Health Care Providers (Do not use this form as a authorization for release of medical records)

Patient Information

Last Name _____ **First Name** _____ **MI** ____ **DOB** ___/___/_____

Home Street Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home Telephone (____) _____-_____ **Alternate Telephone** (____) _____-_____

Information to be Released and/or Shared: CHA has my permission to disclose to and/or communicate with other healthcare providers & hospitals. I understand the information may include details about, but is not limited to, the following for my medical care: Sexually Transmitted Diseases; Domestic Violence; Genetic Testing; Hepatitis; HIV History & Test Results; Domestic Violence; Sexual Assault/Abuse; Behavioral Health; Alcohol and Drug Abuse Treatment (including to the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2.)

TERM: I understand that this authorization will remain in effect until the terms of this authorization expires ***which is one year past my signature date below.***

☐ **Information Obtained From/or Communicated with Hospital, Facility, or Person Below**

Select: ☐Psychiatrist ☐Therapist ☐PCP ☐School ☐Parent ☐Spouse ☐Other Family ☐DMH ☐DCF ☐Residential Program ☐Other: _____

Name: _____

Address: _____ **City:** _____

State: ____ **ZIP:** _____ **Phone:** _____ **Fax:** _____

☐ **Requested information should be forward to the following CHA location:**

Name: _____

Address: _____ **City:** _____

State: ____ **ZIP:** _____ **Phone:** _____ **Fax:** _____

Purpose:

☐ Medical Care ☐ Insurance ☐ Legal ☐ Personal

☐Other: _____

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Information to be Obtained/Released: **(Specify dates)**

☐ Verbal Communication (covers birth through present unless otherwise noted):

_____

☐ Entire Record:

_____

☐ Other (specify type of information):

_____

☐ Record Abstract (e.g. H & P, Test Reports, Discharge Summary):

_____

By my signature below, I hereby authorize Cambridge Health Alliance to disclose my health information including the highly sensitive information. I understand that once Cambridge Health Alliance discloses my health information, Cambridge Health Alliance cannot guarantee that the recipient will not redisclose my health information to a third party who may or may not be required by law to keep my information confidential.

I may refuse to sign or may revoke (at any time) this Authorization for any reason and that, if I do refuse or revoke this permission, this will not affect my treatment at Cambridge Health Alliance. 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 disclosures that occurred prior to the date on which my revocation was received.

I may contact Cambridge Health Alliance's Privacy Officer by mail at 230 Highland Avenue, 6th Floor, Somerville, MA 02143 or through the CHA Health Information Management (H.I.M.) Department.

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

_____

Patient Signature **Date/Time**

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

_____

Signature of Representative **Description of Authority** **Date/Time**