Hallmark Health
www.hallmarkhealth.org

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

DATE OF REQUEST: _____

PATIENT INFORMATION:

NAME: _____ **PHONE #:** _____

ADDRESS: _____ **CITY/STATE:** _____

DATE OF BIRTH: _____ **MEDICAL RECORD #:** _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. I authorize Hallmark Health Corporation to disclose my Protected Health Information ("PHI") as described below to the following individuals/organization (if more space is needed, attach a separate sheet). I understand that employees are prohibited from using their login names and passwords to access my PHI directly. All requests must be processed through the Medical Records Department.

NAME/ORGANIZATION: _____
ADDRESS: _____

NAME/ORGANIZATION: _____
ADDRESS: _____

If more names/organizations are requested, please attach a separate form.

3. I request the disclosure for the following purpose ***(REQUIRED)***:_____
_____
_____

4. The type and amount of information to be used or disclosed is as follows:

TYPE OF REPORT	DATE OF REPORT	TYPE OF REPORT	DATE OF REPORT
Discharge Summary		**Operative Report**	
Radiology/CT Report		**List of Allergies**	
Immunization Record		**Office Notes**	
Laboratory Reports		**Consult**	
Abstract (w/test results)		**Radiology Film**	
History & Physical		**Emergency Room Report**	
Other (specify)		**Other (specify)**	

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the HHC corporate from which this disclosure is sought.

   I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the 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 understand that it is my responsibility to notify HHC that I wish to revoke this authorization. I further understand that HHC is not responsible for disclosures made in reliance of this authorization prior to the date of revocation.

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Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

An expiration date, event or condition is required. Using open ended events such as "Indefinite" or "Until Otherwise Revoked" is prohibited. If I fail to specify an expiration date, event or condition, or if the authorization is open-ended, this authorization will only be used once to disclose my medical/billing records to the above-named requestor. In addition, an expiration date cannot be for more than one (1) year from the date of the request.

6. I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure of the recipient and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Chief Privacy Officer at 781-979-3477.

7. Limitations to disclosure (if any):_____
_____
_____
_____

8. Proof of Legal Representation: If this authorization is signed by some person other than the patient (except in cases where the patient is 17 years old or younger and the requestor is the parent of an unemancipated minor), I understand that I must provide written proof of legal representation prior to HHC disclosing any Protected Health Information (e.g. Provide proof of executorship, guardianship, etc.)

9. I have read this form and agree to the disclosure of all Protected Health Information regarding my treatment including but not limited to: Psychiatric treatment or testing (I understand I must complete a separate form to authorize the disclosure of psychotherapy notes which are not the same as psychiatric treatment or testing), treatment for drug and/or alcohol abuse or use, abortion, treatment for sexually transmitted disease, adoption, social service notes and any other information contained in my record unless I describe other limitations to disclosure in Section 9 of this authorization.

Signature:_____ Date:_____
(Required) Patient/Legal Representative

10. I understand that the information in my medical record contains information relating to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) treatment or testing and I authorize its disclosure.

Signature:_____ Date:_____
(Required) Patient/Legal Representative

If legal representative is signing this form, give relationship:_____
(Provide proof of legal representation as appropriate. i.e. Power of Attorney/ Guardianship documents etc.)

Return Completed Form to the Medical Records Department at the facility in which you received your care:

Medical Records Department
Hallmark Health System
Lawrence Memorial Hospital
170 Governors Avenue
Medford, MA 02155
P: (781) 306-6149
F: (781) 306-6551

Medical Records Department
Hallmark Health System
Melrose-Wakefield Hospital
585 Lebanon Street
Melrose, MA 02176
P: (781) 979-3213 or
(781) 979-3215
F: (781) 979-3217