Hallmark Health System

Authorization to Use & Disclose Protected Health Information

Addendum A: General Use Form

Location: _____

Address: _____

City, Zip: _____

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____

Any other Previous Names: _____

Patient Address: _____ Phone #'s: _____

City: _____ State: _____ Zip: _____ EMAIL: _____

I hereby Authorize Hallmark Health System to:

Please choose one: ○ Release my medical record information to ○ Obtain medical information from

Name/Facility: _____ Attention: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: ○ Personal ○ Medical Care ○ Legal ○ Insurance ○ Other _____

Specific Records/Report(s) to be released:

Treatment Dates: _____

☐ Discharge Summary ☐ History & Physical ☐ Radiology Reports ☐ Radiology CD

☐ Operative Report/Proc Notes ☐ Emergency Room Rpt ☐ Consult Notes

☐ Abstract(Diagnostic Treatment & Provider Notes) ☐ Other _____

***COPY FEE:** Fees may apply to a request for copies but at no time will exceed a reasonable cost-based fee.*

Restricted Authorization to Release Protected Information:

IMPORTANT - Please initial next to each sensitive record category that you wish to disclose and sign in this box below.

Release Records?

_____ **Mental/Behavior Health or Disability Services Provider Documentation ***

_____ **HIV/AIDS Screening Test Results**

_____ **Information about Alcohol and/or Substance Abuse Treatment *****

_____ **Genetic Testing/Test Results ****

_____ **Information about Rape/Sexual Assault Victim's Counseling**

_____ **Information about Sexually Transmitted Disease (STD's)**

_____ **Information about Domestic Violence Victim's Counseling**

Signature: _____ **Date:** _____

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment." 42 CFR Part 2. Does not include records created or maintained by a general medical facility.

I Understand and Agree to these Conditions for Authorization:

Voluntary. Disclosure of this information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

Revocation. I have the right to revoke this authorization at any time and must do so in writing. The revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Request for Review. I may inspect or request a copy of the information to be used or disclosed, as provided in 45 C.F.R. 164.524.

Potential for Redisclosure. Information disclosed in response to this authorization may be disclosed by the recipient and may not be protected by federal or state law.

Expiration. This Authorization will remain in effect for six (6) months unless otherwise specified: _____

Sign Here

Date Here

Signature of Patient's **Date**

Signature of Personal Representative **Date** **Relationship to patient or authority to act for patient**

If you have questions about disclosure of your health information please call Chief Privacy Officer at 781-979-3477.

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