Cooley Dickinson Hospital *OB299*

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

CDH 299 Rev. 10/1/2013

Medical Record #_____

PATIENT FULL NAME: (please print)_____

DATE OF BIRTH: _____ **PHONE**: _____ **CELL PHONE:** _____

INFORMATION REQUESTED: Dates of treatment: _____

☐ Summary ☐ X-ray, CT, MRI reports (**not films**) ☐ Laboratory results ☐ Entire record
☐ Rehab: ☐ OT ☐ PT ☐ Speech-Language
☐ Other (please specify):_____

_____(initial). I understand that the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services and treatment for alcohol and drug abuse

_____(initial). My record may contain information relating to AIDS or HIV.

PERSON/FACILITY TO RECEIVE INFORMATION: PLEASE PRINT CLEARLY

(NAME & ADDRESS)_____ Fax #_____

_____ E-mail_____
For electronic delivery of records

_____ Phone # _____
REQUIRED if different than patient's phone #

Reason for disclosure: _____

I authorize Cooley Dickinson Hospital to release the information specified above. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure. I understand that I have a right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months. I understand that my treatment or continued treatment by CDH is in no way conditioned on whether or not I sign this authorization, and that I may refuse to sign it.

Cooley Dickinson Hospital has the right to **CHARGE A PHOTOCOPY FEE $0.72 PER PAGE** for all photocopy requests, as well as postage fees. Requesting a 'summary' rather than the entire record will significantly reduce this cost. If you are requesting records for follow-up medical care, please allow us to send it directly to your healthcare provider at no charge. Bills for this service will be processed by Healthport. Records will not be photocopied until payment for this service has been made. Requests for release may take 2-3 weeks for handling, depending on current volume of requests and when payment is received.

_____ _____
Signature of Patient or Legal Representative **Date**

If signed by legal representative, relationship to patient: _____ Printed name _____

DEPARTMENT USE ONLY

PROCESSED BY: _____ **ID CHECKED BY:** _____ **MAIL FAX PICKUP EMAIL**
DATE PROCESSED: _____ **(CIRCLE ONE)**