

MILFORD REGIONAL MEDICAL CENTER

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to Milford Regional. I understand that I do not have a right to revoke the authorization if it was as a condition of obtaining insurance coverage or under other applicable law to contest an insurance policy claim. If I choose to revoke authorization, I understand that I may be denied treatment, enrollment in a health plan or eligibility for benefits. I also understand that revocation will not apply to information that has already been released in response to this authorization. I understand that if the organization authorized to receive the information is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Street Address: _____

City or Town, State, Zip Code: _____

Telephone Number: _____ Date of Birth: _____

Person(s)/organization(s) providing the information:

Milford Regional Medical Center

Person(s)/organization(s) receiving the information:

I understand that my medical record may contain sensitive information, including but not limited to, information pertaining to alcohol use/abuse, controlled substance (drug) use/abuse; psychiatric/social services issues; venereal disease and treatment; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) status/treatment/testing (regardless of whether positive or negative results were obtained); domestic abuse treatment or counseling; and sexual assault treatment or counseling. If I choose to limit the information released from my medical record, I have indicated these limitations below:

PLEASE TURN OVER & FILL OUT THE OTHER SIDE

Specific description of information (including date(s) of treatment):

Purpose(s) of the use or disclosure of information: _____

Unless otherwise revoked, the authorization will expire one hundred eighty (180) days after the date signed below. By signing below, I understand and acknowledge that I have read and understand this authorization and, if I have any questions about disclosure of my protected health information, I may contact the Director of Health Information Manager and Milford Regional's Privacy Officer.

*Signature of patient
or patient's representative: _____ Date: _____

(Form must be completed before signing)

Printed name of patient
or patient's representative: _____

Basis of representative's authority to act for patient: _____

Signature of Witness: _____ Date: _____

*If patient is under the age of 18 and is not an emancipated minor, parent or legal guardian (with proof of authority) must sign. If patient is over the age of 18, patient is considered of legal age in the state of Massachusetts and must authorize the release of their records.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

Please note that there is a fee for copies of medical records when requested for personal use.