



Sturdy Health

211 Park Street | PO Box 2963
Attleboro, MA 02703-0963

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Medical Record # _____

Name of Patient/Previous Names

Birth Date

Telephone

Street Address

City/State/Zip

Authorizes: (e.g. hospital, clinic or provider name)

Release of Protected Health

Information To: (e.g. to whom you want the information sent)

Fax Number: _____

Name of Health Care Provider/Plan/Other

Name of Health Care Provider/Plan/Other

Street Address

Street Address

City/State/Zip

City/State/Zip

Sensitive Information:

By initialing next to a category of sensitive information listed below, I specifically authorize the use and/or disclosure of the type of sensitive information indicated next to my initial which might otherwise be subject to special legal protections preventing its use or disclosure:

- Information about Mental Health Communications
- Information about HIV/AIDS Testing or Treatment
(including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).
- Information about Sexually Transmitted Diseases
- Information about Sexual Assault
- Information about Substance (i.e. alcohol or drug) Abuse
- Information about Genetic Testing

(Initial)

Purpose of Disclosure: (Check applicable categories)

☐ Further Medical Care ☐ Insurance Eligibility ☐ Legal Action ☐ Changing Physicians ☐ Personal
☐ Payment of Bill ☐ Other (Specify): _____

I understand that once my health information is disclosed in accordance with the terms and conditions of this authorization, it cannot be guaranteed that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.



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Information To Be Released: (Please check all that apply, and specify dates):

- ☐ Medical Record Abstract/dates _____
(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ☐ Clinic Visit Notes/dates _____
- ☐ Consultation (Specify dates) _____
- ☐ Discharge Summary/dates _____
- ☐ Emergency Room (Specify dates) _____
- ☐ Lab Reports/dates _____
- ☐ Operative Reports/dates _____
- ☐ Pathology Reports/Dates _____

- ☐ Physical Therapy (Specify dates) _____
- ☐ Radiology Reports/dates _____
- ☐ Billing Records/dates _____
- ☐ Other (please specify below and include dates) _____

Your Rights with Respect to this Authorization:

Right to Refuse to Sign Authorization – I understand that I may refuse to sign this authorization and that such refusal will not affect my health care or payment for my health care that is provided at Sturdy Memorial Hospital, or Sturdy Health Medical Group.

Right to Revoke Authorization – I understand written notice is necessary to revoke this authorization. Such notice should be sent to: Sturdy Memorial Hospital, Health Information Management Department, 211 Park Street, P.O. Box 2963, Attleboro, MA 02703-0963, and will immediately become effective, upon receipt. I am aware that revoking my authorization will not affect any information previously released with an authorization.

Expiration Date: This Authorization Expires 90 days from the date of signature below.

I have had an opportunity to review and understand the content of this authorization form.
By signing this authorization, I am confirming this accurately reflects my wishes.

Signature of Patient

Date

Time

If the patient is a minor or is otherwise unable to sign this authorization, obtain the following signature:

Signature of Personal Representative

Relationship or Authority

Date

WITNESS: _____