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

Street Address

City/State/Zip

Name of Health Care Provider/Plan/Other

Street Address

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: (Initial)

- 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 _____

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.

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

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)*	☐ Physical Therapy *(Specify dates)*_____
☐ Clinic Visit Notes/dates_____	☐ Radiology Reports/dates_____
☐ Consultation *(Specify dates)*_____	☐ Billing Records/dates_____
☐ Discharge Summary/dates_____	☐ Other *(please specify below and include dates)*_____
☐ Emergency Room *(Specify dates)*_____	_____
☐ Lab Reports/dates_____	_____
☐ Operative Reports/dates_____	_____
☐ Pathology Reports/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: _____