



Manet Community Health Center

Manet Community Health Center
9 Bicknell Street
Quincy MA 02169
Secured Fax Line: 617-774-6489

Authorization to Obtain Protected Health Information

Patient Name:		Date of Birth:	
Address:	City:	State:	Zip:
Email:	Phone: (H):	(W)	(C)

I hereby authorize **Manet Community Health Center, Inc.** to Obtain my health information from: (Please list below)

Name (of facility): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax#: _____ Email: _____

Format of information to be released: (please check box) Paper Fax Encrypted CD

I wish to pick up my records: (medical records will contact you when ready for pick-up)

Please specify information to be released or obtained: check all that apply; only checked items will be released

- Complete Records Partial Records (last two years) Lab Results Immunizations Medication List
- Imaging Reports Prenatal/GYN Records Eye Records Problem List

Please specify information to be released or obtained: check all that apply; only checked items will be released

- Behavioral/Mental Health HIV/AIDS Results/Treatment Domestic Violence Abortion Genetic Testing
- Sexually Transmitted Disease Alcohol/Drug Abuse Rape Sexual Assault Child/Elder/Disabled Abuse

Purpose for requested information: Legal Insurance Specialist/Procedure Transferring out of Manet Other

By signing this authorization, I understand that:

- This authorization will remain in affect for 90 days after the above date or as specified: _____
- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations
- I have the right to revoke this authorization at any time. Revocation must be made in writing to the Medical Records Department. Revocation will apply to information that has already been disclosed in response to the authorization.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization
- I also understand that this information may be re-disclosed by the recipient if the recipient is not required to follow the privacy regulations or statutes.

I have read and understand the terms of this authorization.

Patient/Parent/Legal Guardian Signature

Date