Manet Community Health Center

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

Authorization to Release 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 Send my health information to: (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** ☐

Release of information regarding specific consent. The following categories of information in your medical record **WILL NOT** be released without your specific authorization, indicated by initialing each appropriate category.

☐ **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 effect 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**