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

Authorization to Share or Disclose Protected Health Information

Patient Name: Date of Birth:
Address: City: State: Zip:
Email: Phone: (Home): (Work) (Cell)

I hereby authorize Manet Community Health Center, Inc. to share my health information as indicated below

Obtain from:
☐ **Manet Community Health Center**
☐ Other: (specify below)

Name (of facility): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax#: _____

PURPOSE
☐ Medical Care ☐ Personal ☐ Insurance
☐ Legal Matter ☐ Transferring out of Manet
☐ Other (specify)
_____

Release to:
☐ **Manet Community Health Center** (If obtaining from other)
☐ Self (Patient address above)
☐ Other: (specify below)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

HIM Method of Record Delivery (Choose One):
☐ Fax#:_____
☐ Email:_____
☐ Paper Copy via postal mail to the address noted above
☐ Pick up at **9 Bicknell Street, Quincy, MA 02169**

Complete Section if applicable for releasing medical records
Please specify information to be released or obtained: check all that apply: only checked items will be released

☐ **Last Visit** | ☐ **Partial Record** (Last 2 years) | ☐ **Complete Records**

☐ **Lab Results** | ☐ **Immunizations** | ☐ **Medication List** | ☐ **Imaging Reports** | ☐ **Prenatal/GYN Records**

☐ **Eye Records** | ☐ **Last Physical** | ☐ **Pap Smear** | ☐ **Colonoscopy** | ☐ **Mammogram**

☐ **Other**_____

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 selecting **Yes** or **No** each appropriate category.

☐ Yes ☐ No **HIV/AIDS Results/Treatment** | ☐ Yes ☐ No **Domestic Violence** | ☐ Yes ☐ No **Abortion** | ☐ Yes ☐ No **Genetic Testing**

☐ Yes ☐ No **Sexually Transmitted Disease** | ☐ Yes ☐ No **Alcohol/Drug Abuse** | ☐ Yes ☐ No **Rape Sexual Assault**

☐ Yes ☐ No **Child/Elder/Disabled Abuse** | ☐ Yes ☐ No **Behavioral Health**

Processing times may vary based on selections, potentially extending up to 3 weeks due to the volume of information in the patient record.

By signing this authorization, I understand that:

- This authorization will remain in effect for 1 year 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.

Printed name	**Patient/Parent/Legal Guardian Signature**	**Date**