



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 or Other
Release to: Manet Community Health Center, Self, or Other
Name, Address, City, State, Zip, Phone
PURPOSE: Medical Care, Personal, Insurance, Legal Matter, Transferring out of Manet, Other
HIM Method of Record Delivery: Fax#, Email, Paper Copy, 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