Holyoke Health Center, Inc.
230 Maple Street ❖ P.O. Box 6260
Holyoke, MA 01041-6260
PHONE: 413-420-2200 ❖ TTY: 413-534-9472 FAX: 413-420-2280

We are required by law to obtain your written permission to release or obtain your medical/dental information

Patient's Information

Patient's Name _____ Patient's Date of Birth ___/___/_____
Last First Middle

Other name(s) used as a patient here: _____

Telephone: (____) _____ - _____ Email: _____

Address _____ City _____ State _____ Zip _____

☐ I authorize the Holyoke Health Center Inc., to **RELEASE** the indicated portions of my medical/dental records to the following Provider or facility:

☐ I authorize the Holyoke Health Center Inc., to **OBTAIN** the indicated portions of my medical/dental records from the following Provider or facility:

(Name and/or Facility): _____

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

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

Reason for Request:

☐ Personal use ☐ Transfer of care ☐ Referral/Specialist ☐ Legal Matter ☐ Employment

☐ Government related ☐ Other: _____

Indicate the medical/dental documents you agree to have released by checking the box and initialing below:

☐ _____ Recent Physical exam only ☐ _____ Immunizations only

☐ _____ Recent Lab Results only ☐ _____ Other: (specify)_____

☐ **_____ Full Medical Record**

☐ _____ Dental **Record** Only ☐ _____ Dental **X-rays** Only ☐ _____ Dental **Record with X-rays**

Date Range of Services: Form _____/_____/_____ to _____/_____/_____ or ☐ All Dates of Service

I understand that if my record has any of the following information it CANNOT be released. Indicate any **additional information** that you agree to be released by checking the box and **initialing** below. ***These documents will not be released without your consent!***

- ☐ ___ Alcohol or Drug Abuse Treatment *****
- ☐ ___ Sexually Transmitted Diseases
- ☐ ___ Genetic Information
- ☐ ___ HIV/AIDS Counseling/Treatment
- ☐ ___ Domestic Violence Counseling/ Treatment
- ☐ ___ Sexual Assault Counseling/ Treatment
- ☐ ___ Behavioral Health/Psychotherapy
- ☐ ___ Other: _____

***Protected by Federal Confidentiality Rules 42 CFR Part 2** (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2)

DELIVERY METHODS – Please deliver my records:

☐ As a paper printout ☐ By regular mail ☐ On a USB drive ☐ By Fax: **( ) _____ - _____**

If you are sending information to Holyoke Health Center Inc., please send to the following facility:

☐ **Holyoke Health Center**
230 Maple St
Holyoke, MA 01040
P: (413)420-2200
Medical Fax:
(413)420-2280
Dental Fax:
(413)420-2250

☐ **Chicopee Health Center**
505 Front St
Chicopee, MA 01013
P: (413)420-2222
Medical Fax:
(413)592-3382
Dental Fax:
(413)592-2324

☐ **Holyoke Health Dental Clinic**
Holyoke Soldiers Home
110 Cherry St
Holyoke, MA 01040
P: (413)420-6270
F: (413)536-6272

☐ **Holyoke Health Dental Clinic**
Western Massachusetts Hospital
91 East Mountain Rd
Westfield, MA 01085
P: (413)420-6260
F: (413)562-3380

Individual Rights: I understand and agree that:

- I may refuse to sign this authorization.
- I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing by sending written notification to the Privacy Officer at 230 Maple St. Holyoke, MA 01040.
- My right to revoke does not apply to information that has already been sent in response to this request.
- My treatment is not conditional upon this authorization.
- I have the right to inspect or obtain a copy of this medical/dental record as stated in federal privacy regulation CFR 164.524
- I understand that information used or disclosed because of this authorization may be disclosed by the recipient and may no longer be protected by federal or state law unless the records pertain to the Substance Use Disorder Records: 42 CFR part 2 prohibits unauthorized disclosure of these records.

With my signature the information specified above will be requested from the recipient designated above.

The Authorization is valid for 365 days from date of signature unless I indicate a different time or reason for expiration. See date ranges on other page. Once the information has been released, Holyoke Health Center Inc. cannot guarantee that the Recipient will not re-disclose the information to another party who may not be required to comply with state and/or federal laws governing the use and disclosure of protected health information (PHI) and, in such case, the PHI described above may be re-disclosed and would no longer be protected by such laws governing privacy of health information.

Release may take 10-15 business days for records to be processed and released. I will be notified when the records are ready for release. I am aware that there may be a fee for providing copies of my medical/dental record.

I have carefully read and understand the terms of this Authorization. I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize the disclosure of the above protected health information to the designated person/entity as specified above. I give my permission to share my protected health information, which may include protected or privileged information, in written and/or other stored format.

Patient/Guardian Signature: _____ Date: ____/_____/_____

If not signed by person served, specify relationship: · Parent · Legal Guardian/Designee

☐ **I authorize the following to pick up my records:**
Name: _____ Date: ____/_____/_____