Hilltown Community Health Center

AUTHORIZATION TO OBTAIN/DISCLOSE CLINICAL INFORMATION

By completing this form, you are authorizing the disclosure and/or use of your protected health information. Completing this form authorization Hilltown Community Health Centers, Inc. to verbally/physically release/obtain your clinical records when this authorization is received. IF YOU DO NOT PROVIDE ALL OF THE REQUESTED INFORMATION, THIS AUTHORIZATION WILL NOT BE VALID.

PATIENT NAME: _____ PATIENT DOB: _____
PREVIOUS NAME(S): _____
PATIENT ADDRESS: _____
PHONE NUMBER: _____

Please select to which department(s) this authorization applies:

- ☐ MEDICAL
- ☐ DENTAL
- ☐ BEHAVIORAL HEALTH
- ☐ OPTOMETRY
- ☐ HILLTOWN SOCIAL SERVICES

Please select to which location this authorization applies:

- ☐ WORTHINGTON HEALTH CENTER
  58 Old North Road, Worthington, MA 01098
  Phone (413) 238-5511 / Fax (413) 923-9355
- ☐ HUNTINGTON HEALTH CENTER
  73 Russell Road, Huntington, MA 01050
  Phone (413) 667-3009 / Fax (413) 923-9355
- ☐ SCHOOL-BASED HEALTH CENTER
  12 Littleville Road, Huntington, MA 01050
  Phone (413) 667-0142 / Fax (413) 667-0145
- ☐ HILLTOWN COMMUNITY SERVICES
  9 Russell Road, Huntington, MA 01050
  Phone (413) 667-2203 / Fax (413) 667-2225

Please INITIAL any and/or both of the options listed below:

_____ I specifically authorize the release of clinical information **TO BE SENT TO HILLTOWN COMMUNITY HEALTH CENTERS, INC.**

_____ I specifically authorize the release of clinical information **TO BE SENT FROM HILLTOWN COMMUNITY HEALTH CENTERS, INC.**

NAME OF PARTY TO RECEIVE/SEND INFORMATION: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

Phone Number: _____ Fax Number: _____

OVER

Individual Rights

- I understand that any disclose of information carries with it the potential for an unauthorized re-disclosure.
- I understand that I have the right to revoke this authorization at any time.
- I understand that in order to revoke this authorization, I must do so in writing.
- I understand that this revocation will not apply to the information that has already been released in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the law providers my insurers with the right to contest a claim under my policy.
- I understand that copy charges may apply according to policy.

Check all information to be released:

- ☐ All
- ☐ Most Recent Office Visit
- ☐ Most Recent Complete Physical Exam
- ☐ Immunizations
- ☐ Lab Results
- ☐ Diagnostic Imaging (X-Rays, CT, MRI, etc.)
- ☐ Vision Records
- ☐ Dental Records
- ☐ Dental X-Rays
- ☐ Behavioral Health Treatment
- ☐ Other (please specify): _____

Please note that this release will be null and void unless initialed below, meaning that HCHC cannot release the records that you have requested. Doing so, does not mean you are necessarily stating that you have a substance abuse problem and/or HIV; rather that you understand your record is protected by Federal statue whether you do or not.

INITIAL: _____ I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. I understand that my records are protected under federal regulations governing Confidentiality or Alcohol and Drug Abuse Patient Records (42 CFR part 2) and cannot be disclosed without my written consent unless otherwise provided for in the federal regulations. The recipient of drug and/or alcohol abuse information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

INITIAL: _____ I specifically authorize the release of personal health information relating to Acquired Immunodeficiency Infection (AIDS) or Human Immunodeficiency Syndrome (HIV).

I HAVE HAD AN OPPORTUNITY TO REVIEW AND UNDERSTAND THE CONTENT OF THIS AUTHORIZATION FORM. BY SIGNING THIS FORM, I AM AUTHORIZING HILLTOWN COMMUNITY HEALTH CENTERS, INC. TO SEND OR/OR RECEIVE PROTECTED HEALTH INFORMATION AND THAT IT ACCURATELY REFLECTS MY WISHES.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

_____ _____

PRINT YOUR NAME RELATIONSHIP TO PATIENT

This authorization will expire in 180 days unless revoked by a specified event, date, or condition: _____