



MRN _____

HILLTOWN COMMUNITY HEALTH CENTERS, INC

"This Institution is an Equal Opportunity Provider"

Permission to Share Information

If you want the Hilltown Community Health Center, INC to share information about you, for your own records, with another person or organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, (Name) _____, DOB _____, City _____
State _____ ZIP _____ give my permission to share the information
about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

Check all information to be released

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

Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

____ I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____ I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

____ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

Name and/or Organization

Street City State Zip

Phone Number Fax Number



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SECTION V – Who May Receive My Information

The person or organization listed in Section IV may receive the information I listed in Section II with this person(s) or organization:

Name and/or Organization

Street Address

City

State

Zip

Phone Number

Fax Number

Send by: Mail (\$20+postage) Fax (Free) Picked up in person (\$20 Paper, \$5.00 CD) MyChart (Free)

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts

This permission to share my information is good until (date) _____.

If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to Hilltown Community Health Center, INC, and send it or bring it to the place where I am now giving this permission. If the information has already been given out, I understand that it is too late for me to change my mind and cancel the permission.
- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V and that I am doing this voluntarily.
- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature

Please sign and date this form and print your name.

Your Signature

Date

Print Your Name

If this form is being filled out by someone who has legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____

For Internal Use Only

Date request received: _____ Received by: Mail email Dropped off in person MyChart

Date released: _____ Information released/ reviewed by: _____

Records sent by: Mail Fax Picked up in person MyChart

Revocation

Requested by: _____

Date Revoked: _____

Initials of Privacy Official: _____