



Dear Patient,

When requesting information from your medical record, it is important to remember that all physician offices are bound by very strict federal laws regarding the release of sensitive information. Our number one concern is to make this process as easy for you as possible so you can receive the requested information quickly. So it is important that you fill out the **AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION** completely and accurately so we can release the information you have requested. Please print and mail or fax to the location of your physician. Addresses for all our locations can be found on our website, www.pmaonline.com.

Our fee for retrieving your record, reviewing and copying the requested information and mailing it to you is \$20.00. You may pay by cash, check or credit card.

___ VISA

___ MASTERCARD

Acct. No: _____, Exp. Date: _____

Name as it appears on card

Name of Patient

Date of Birth

The information you requested will be mailed to you within 14 days of receipt of your signed authorization form and the fee.

If you have any questions please feel free to call the Pentucket Medical, Medical Record Department:

| | <u>PHONE</u> | <u>FAX</u> |
|---------------------------------|-----------------------|-----------------------|
| Haverhill: | (978) 469-5459 | (978) 469-5395 |
| RiverWalk/North Andover: | (978) 557-8816 | (978) 557-8777 |
| Newburyport: | (978) 499-7259 | (978) 499-7388 |
| Georgetown: | (978) 352-8375 | (978) 352-8582 |



Authorization for Release of Your Medical Information

1. Patient Name: _____ Date of Birth: _____

2. Patient Address: _____

3. Patient Phone Number: _____

4. Patient Statement:

I _____, _____
(Name) (Date of Birth)

Authorize: _____

_____ to release
(Name and address of facility)

health information including copies of my medical record to the following:

Name(s)/Facility:

Address:

5. Reason for the Information Transfer Request, (please check):

___ Referral, ___ Legal Matter, ___ Insurance, ___ Other,

___ Transfer to New Primary Care Physician, ___ Transfer to a new Specialist

6. Information to be Released, (check the appropriate item and specify dates):

___ 2 years of Medical Record Information

___ My Entire Medical Record

___ Other, (specify) _____

7. I request the release of the categories of information I have initialed below:

(Initial)

_____ HIV Test Results, Dates: _____

_____ Genetic Test Results, Please specify the type of test: _____

_____ Alcohol and Drug Abuse Records
(Federal rules prohibit any disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal Confidentiality Rules 42 CFR Part 2.)

_____ Other(s) Please list _____

Confidential Details of:

_____ Psychotherapy, (from a psychiatrist, psychologist, or mental health clinical nurse)

_____ Social Work Counseling/therapy

_____ Domestic Violence Victims' Counseling

_____ Sexual Assault Counseling

_____ Treatment of Anxiety or Depression

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Medical Records Department. Authorization may be withdrawn except for the following:
 - To the extent that action has been taken in reliance on this authorization.
 - If the authorization is obtained as a condition of obtaining insurance coverage.
- I may refuse to sign this authorization which will not affect my treatment, payment, health plan enrollment or eligibility for benefits.
- Information released, if further disclosed by the recipient is no longer protected by Partners HealthCare.
- I understand that this authorization will automatically expire: (please check one):

_____ In six months.

_____ Upon a specific event. (Please specify) _____

I have read and understand the above, have had any questions explained to my satisfaction and voluntarily authorize disclosure of the above information to those persons or agencies listed above.

Patients Signature: _____ Date: _____

Print Name: _____

If the patient is a minor or not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative

Date: