Pentucket Medical

PARTNERS HEALTHCARE

**Please complete only if you are leaving the practice**

As the Executive Director of Pentucket Medical I am concerned about the perception of our practice by our patients. Please take a few minutes to complete this short survey. If you are leaving the practice for any reason except an insurance change or relocation, it would be very helpful to me to know why. If you wish to speak to me directly, please call or email me anytime at (978) 469-5586 or jsarro@pmaonline.com.

**Thank you for your help.**
**John J. Sarro**

Your Pentucket Medical Primary Care Physician or Specialist is: _____

You are transferring to Dr.: _____

The reason you are transferring your care is:

**Please Check One or More**

- New insurance not accepted by Pentucket Medical: _____

  Your new insurance carrier is?

  _____

- Relocation from the area, where? _____

  _____

- Hospital Preference: _____

  Which hospital do you prefer?

  _____

- **Dissatisfaction with your PCP/Specialist** _____
- **Dissatisfaction with the nursing or reception staff** _____
- **Dissatisfaction with any other aspect of Pentucket Medical:** _____

**If any of these three are the reason, please explain your reasons on the back of this form and/or call or email me.**

PARTNERS® Pentucket Medical

Dear Patient,

If you are requesting copies of 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.

Please be aware there is a fee associated with the retrieval, reviewing and copying of the requested information.

For Medical **Record Abstract 0- 3 Years** (e.g. History and Physicals, Op-Report, Consult, Test Results, Discharge Summary, Office Visits **the fee is $6.50.**

**For all other request the fee will be per the Massachusetts General Law which is as follows:**

**$24.37** for clerical and administrative expenses **plus**
**$0.82** per-page charge for the *first 100 pages* copied; and
**$0.42** per-page charge for *each page in excess of 100 pages*.

You may pay by 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 the Massachusetts statue of 30 days from the receipt of your signed and completed authorization form and payment.
If you have any questions please feel free to call the Pentucket Medical, Medical Record Department:

| | PHONE | FAX |
|---|---|---|
| **Haverhill:** | **(978) 469-5459** | **(978) 469-5395** |
| **Haverhill Pedi** | **(978) 469-5337** | **(978) 521-3256** |
| **River Walk:** | **(978) 557-8816** | **(978) 557-8777** |
| **Newburyport** | **(978) 499-7289** | **(978) 499-7388** |
| **Andover** | **(978) 469-5459** | **(978) 469-5395** |

Pentucket Medical

Merrimack Valley Endoscopy Center

PARTNERS HEALTHCARE

Mail or Fax to:

_____

_____

_____

# AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

## A. PATIENT INFORMATION

**PATIENT NAME:** _____ **DATE OF BIRTH:** _____

**PATIENT MEDICAL RECORD #** _____

**PATIENT ADDRESS:** _____ **APT. #:** _____

**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

**TELEPHONE CONTACT:** **DAY: (** **)** _____ **EVENING: (** **)** _____

## B. PERMISSION TO SHARE: I give my permission to share my protected health information.

**From:**

Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

**Send by:**

[ ] Mail

[ ] Electronically (secure email)

Email Address: _____

**To:**

Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

**Purpose** (check the appropriate box)

[ ] Medical Care* [ ] Transfer from practice

[ ] Insurance* [ ] Other (please specify)*

[ ] Legal Matter* _____

[ ] Personal*

[ ] School *Copying fees may apply

## C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

[ ] Medical Record Abstract/dates _____
*(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)*

[ ] Clinic Visit Notes/dates _____

[ ] Discharge Summary/dates _____

[ ] Lab Reports/dates _____

[ ] Operative Reports/dates _____

[ ] Pathology Reports/dates _____

[ ] Radiation Reports/dates _____

[ ] Radiology Reports/dates _____

[ ] Photographs/dates (costs may apply) _____

[ ] Billing Records/dates _____

[ ] Other *(please specify below and include dates)* _____

_____

_____

_____

_____

Pentucket Medical

PARTNERS®

Merrimack Valley Endoscopy Center

# AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

**D. Please check YES to indicate if you give permission to release the following information if present in your record:**

[ ] Yes **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
**SPECIFY DATES** _____

[ ] Yes **Genetic Screening test results (SPECIFY TYPE OF TEST)** _____

[ ] Yes **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

[ ] Yes **Other(s):** Please List: STD Testing, Bipolar Disorder, Schizophrenia, History of Domestic Violence

[ ] Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) *(I understand that my permission may not be required to release my mental health records for payment purposes)*

[ ] Yes Confidential Communications with a Licensed Social Worker

[ ] Yes Details of Domestic Violence Victims' Counseling

[ ] Yes Details of Sexual Assault Counseling

**E. I understand and agree that:**

- Partners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHS may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - [ ] if PHS has already relied upon it (for example, once information is released, it will not be retrieved)
  - [ ] if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself. This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
- My questions about this authorization form have been answered

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **Print Name:** _____

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

**Signature of Legal Representative:** _____ **Date:** _____

**Print Name:** _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date _____

Clinic/Office: _____

Pick-up Identification:

_____ License _____ State ID _____ Passport _____ Other Photo ID _____