UPHAM'S CORNER HEALTH COMMITTEE, INC.
d/b/a
Upham's Community Care
Health Center | PACE | Home Health Care
500 Columbia Road
Dorchester, MA 02125
Pho:(617) 287-8000 / Fax: (617)287-1500

Upham's Community Care
Serving the community since 1971

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

I, or the parent/guardian of the patient named below, understand that I have the right to inspect my protected health information at UCHC, to receive a copy of my protected health information (or designate and authorize someone else to receive a copy of it), or any combination of such. I understand that my request to access my records may be subject to some legal limitations and/or limitations established by the federal government and enforced by a licensed healthcare professional to assure my health and safety and the safety of others.

PATIENT INFORMATION

PATIENT NAME:_____ PATIENT DATE of BIRTH: _____

PATIENT ADDRESS – STREET: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE CONTACT #: _____ ALTERNATE TELEPHONE #: _____

PLEASE CHECK THE BOX BELOW TO INDICATE YOUR REQUEST:

- ☐ I would like to inspect the records identified below (during regular business hours at UCHC)
- ☐ I would like to receive a paper/printed copy of the records identified below
- ☐ I would like to receive an electronic copy of the records identified below in the following format:
  - ☐ Securely Through **MyChart**
  - ☐ USB/Zipdrive [*UCHC charges for the cost of the USB/zipdrive*]
  - ☐ Email: _____
- ☐ Please mail/email the records to me at the address above
- ☐ I will pick up the records at UCHC
- ☐ I would like the following person or entity to receive or sent (as indicated) a copy of the records identified below:

☐ **TO** ☐ **From**

Upham's Corner Health Committee, Inc.
(*Name of Person or Facility*)
500 Columbia Road
(*Address*)
Dorchester, MA 02125

☐ **TO** ☐ **From**

_____
(*Name of Person or Facility*)
_____
(*Address*)
_____

PURPOSE (CHECK): ☐ **MEDICAL CARE** ☐ **LEGAL MATTER** ☐ **PERSONAL** ☐ **SCHOOL** ☐ **INSURANCE**
☐ **TRANSFERRING CARE** ☐ **OTHER (Please Specify):** _____

INFORMATION TO BE RELEASED (Please check all that apply, and specify dates)

- ☐ Clinic Visit Notes [Date(s): _____]
- ☐ Lab Reports [Date(s): _____]
- ☐ Radiology Reports [Date(s): _____]
- ☐ Most Recent Physical
- ☐ Immunizations
- ☐ Pharmacy Co-Payment Records [Date(s): _____]
- ☐ Billing Records [Date(s): _____]
- ☐ Other (Please specify and include dates): _____

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Please check "YES" to indicate if you authorize the release of the following information (if in your records):

☐ YES **HIV test results** (Authorization required for each release request)
☐ YES **HIV/AIDS medical treatment information**
☐ YES **STI (Sexually Transmitted Infection) test results & medical treatment information** (Other than HIV/AIDS)
☐ 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 **Details of Mental Health Diagnosis and/or Treatment** provided by a Psychiatrist, Psychologist, or Licensed Mental Health Clinician (*I understand that my permission may not be required to release my mental health records for payment purposes)*
☐ YES **Details of Domestic Violence Victims' Counseling**
☐ YES **Details of Sexual Assault Counseling**

I understand and agree that:

- Upham's Corner Health Committee, Inc. (UCHC) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at UCHC 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 revoke this authorization at any time by submitting a written request to the Medical Records Supervisor at UCHC, except:
  - if action has already been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- This authorization will automatically expire **in 90 days or otherwise as indicated***:*
  ☐ Upon a specific event or date *(SPECIFY EVENT OR DATE)*_____

**NOTE: If you are signed up for MyChart, you have access to your medical records.*

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

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 to Patient: _____

For Internal Use Only

Form Reviewed and Information Released By: _____ *Date*: _____

In Person Pick-up Identification, (circle one): *License* *State ID* *Passport* *Other Photo Identification*

Form Version – May 2021