



Medical Records Department 269 Union Street Lynn, MA 01901  
781-581-3900 fax 781-598-8136

**Authorization to Release Protected Health Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone (H): \_\_\_\_\_ (W) or (C): \_\_\_\_\_

I hereby authorize Lynn Community Health Center to **send** my medical records to:

Name (or facility): \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ Fax#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(only complete this section if we are getting records from another provider or facility for LCHC)

I hereby authorize Lynn Community Health Center to **obtain/get** my medical records from:

Name (or facility): \_\_\_\_\_ Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ Fax#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**\*\*\*Please specify information to be released or obtained: check all that apply:**

- Copy of my medical records for the past two years: \_\_\_\_\_
- Copy of complete records: \_\_\_\_\_ Date(s): \_\_\_\_\_
- Lab results: \_\_\_\_\_ Date(s): \_\_\_\_\_
- Clinic office notes: \_\_\_\_\_ Date(s): \_\_\_\_\_
- History & Physical: \_\_\_\_\_ Date(s): \_\_\_\_\_
- Behavioral Health: \_\_\_\_\_ Date(s): \_\_\_\_\_
- Substance Abuse: \_\_\_\_\_ Date(s): \_\_\_\_\_
- Medication List: \_\_\_\_\_ Problem List: \_\_\_\_\_
- Other: \_\_\_\_\_ Date(s): \_\_\_\_\_

Purpose of Disclosure: Continuity of Medical Care Legal Insurance Personal

Leaving Lynn CHC Other \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the following person to pick up my medical records for me:

\_\_\_\_\_ relationship to patient: \_\_\_\_\_

Check here if you are requesting copies of your own medical record and would prefer to receive them in electronic format (via secure e-mail). Please provide a valid e-mail address:

\_\_\_\_\_

(limited amount of records can be sent via email due to size limit)

How would you like your records delivered?

Paper  Home delivery  In person-pick up  CD  Fax  USB

**Special Authorization for Release of Statutorily Protected Information from the Medical Record:**

Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical records):

Yes  No HIV/ AIDS Results/ Treatment (patient authorization required for each release request)

Specify Dates: \_\_\_\_\_

Yes  No Genetic Testing (specify type of test) \_\_\_\_\_

Yes  No Alcohol/ 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 42CFR Part 2.) This consent may be revoked upon oral or written request.

Yes  No Abortion

Yes  No Behavioral/ Mental Health Diagnoses and / or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC)

Yes  No Domestic Violence  Yes  No Child/Elder/ Disabled Abuse

Yes  No Rape/Sexual Assault  Yes  No Sexually Transmitted Diseases

I understand and agree that:

\*This authorization will remain in effect for 90 days after the above date or as specified:

\_\_\_\_\_

I understand that I may revoke this authorization at any time by providing the medical record department with a written revocation, and that the revocation will be honored except to the extent that this authorization has been acted upon. I understand that I am under no obligation to sign this and I have read and understand the terms of this medical records release authorization.

- 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.

Patient/Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail or fax this authorization to the address below:

Lynn Community Health Center

Medical Records Department

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