



Medical Records Department 269 Union Street Lynn, MA 01901
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 _____

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Patient Name: _____ Date of Birth: _____

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

_____ relationship to patient: _____

How would you like your records delivered?

- Paper Home delivery In person-pick up CD Fax

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

269 Union Street Lynn, Mass 01901 (781) 581- 3900 fax (781)-598-1050

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