Medical Records Department 269 Union Street Lynn, MA 01901
781-581-3900 fax 781-598-1050

## 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: _____**

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**(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: _____**

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*****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_____

**Revised 9/2017**

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

**Revised 9/2017**