Authorization for Release of Protected Health Information
Permission to Share Protected Health Information

If you want to give Valley Medical Group permission to share or receive protected health information about you with another person or organization, please make sure that you fill out all of the sections below (Sections 1 to 8). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section 2(B), your permission will not be valid, and we will not be able to share your protected health information with the person(s) or organization you listed on this form.

SECTION 1

I, ____(print your name and date of birth) give my permission for___________________________________(Fill in name of person or organization) to share protected health information about me that I list in Section 2 with the person(s) or organization that I list in Section 5.

SECTION 2

A. Protected Health Information

Please describe the information you want to share about you. ____

(Fill in name of person or organization)

(Last 2 years of records will be released unless specified below)

(CHECK ALL INFORMATION TO BE RELEASED)

- ☐ Copies of medical records, including all office visits and diagnostic test reports, from _________ to ____________
- ☐ Immunization records
- ☐ Other (explain)____ (include dates)

B. Permission about Specific Protected Health Information. Only if you choose to share any of the following information, please write your initials on the line:

____I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

____I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

___I specifically give permission to share information in my records about behavioral health treatment (e.g., treatment by a psychiatrist, psychologist, mental health counselor or licensed clinical social worker).

____ I specifically give permission to share details of confidential communications with a domestic violence victims' counselor.

SECTION 3 — Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write. "at my request," if you are initiating the request.

____

____

____

____

SECTION 4 - Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section 2:

Name

Organization

Address

SECTION 5 — Who May Receive My Information

The person or organization listed in Section IV may share the information I listed in Section 2 with this person(s) or organization:

Name

Organization

Address

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION 6 — How Long This Permission Lasts

This permission to share my information is good for one year from the date it is signed.

SECTION 7 – Understand and Agree

I understand and agree that:

- I can change my mind and cancel this permission at any time. To do this, I need to submit a written request or bring it to the place where I originally submitted my written permission to release or share my protected health information. If the information has already been released or shared, I understand that it is too late for me to change my mind and cancel the permission.
- I do not have to give permission to share my information with the person(s) or organization I listed in Section 5.
- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION 8 - Signature

Please sign and date this form, and print your name.

____

Signature

____

Print Your Name

____

Date

If this form is being filled out by someone who has the legal authority to act for the patient (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: ______________________________

Signature of the person filling out this form: ______________________________

Relationship to Patient: ______________________________ Date: ______________________________