

Authorization to Disclose Medical Record Information

Completed by (For office use only):

Initials: _____ Dept: _____ Date: _____

Patient Information

Patient's Name: _____ MRN: _____

Patient's Address: _____ D.O.B: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information *I hereby authorize Fallon Clinic to:*

Mail my medical records to: **Obtain my medical records from:**

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of request: Personal Continuing care (referral/2nd opinion) Transfer of care (new physician)

Legal Insurance Other: _____

Copy Fee: Fallon Clinic reserves the right to charge a reasonable fee for the cost of producing and mailing copies based on M.G.L. Chapter 111 Section 70. See reverse side for details .

Information to be Released *Please be specific—include dates of treatment and provider's name if applicable.*

_____ Date(s) of treatment: _____

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Statutorily Protected & Sensitive Information

Your informed consent is required to release records containing the information below. Please check and initial those categories which you are authorizing to be released.

Mental Health Initials: _____

Alcohol/Substance Abuse Initials: _____

HIV Initials: _____

Sexually Transmitted Disease(s) Initials: _____

Depression/Anxiety Initials: _____

Domestic/Sexual Assault Initials: _____

Genetic Testing Initials: _____

Abortion Initials: _____

I understand that I have a right to revoke this authorization at any time by providing a written statement to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand, unless otherwise revoked or specified, this authorization is valid for twelve months.

Please specify an expiration date if other than twelve months: _____.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signatures

Patient/Legal Representative Signature: _____ Date: _____

If signed by Legal Representative, Relationship to Patient: _____

Witness' Signature: _____ Date: _____



Dear Valued Patient:

Thank you for your request for a copy of your medical record. We appreciate the opportunity to service your *Release of Information* medical record request.

As you can hopefully understand, the cost for the reproduction of medical record requests is quite extensive. In addition, we are bound by HIPAA (Federal Privacy Act) to track and report each request. Therefore, in order to fulfill your request, a bill will be sent to you asking for an upfront fee according to amount of pages copied based on Massachusetts State Law (*sited below*). Your request will be fulfilled upon receipt of payment. ***Please Note: We accept VISA, MasterCard, American Express and personal checks only.***

Should you have any questions regarding the fee, please contact Bactes (our copying services) at (978) 922-0016. For other questions or concerns, please feel free to call the Medical Records Department at (508) 721-1142.

Thank you again for your confidence in Fallon Clinic.

Sincerely,

***Fallon Clinic
Medical Records Department***

**GENERAL LAWS OF MASSACHUSETTS – PART I.
ADMINISTRATION OF THE GOVERNMENT – TITLE XVI. – PUBLIC HEALTH**

CHAPTER 111. PUBLIC HEALTH – HOSPITALS

Chapter 111: Section 70 Records of hospitals or clinics; custody; inspection; copies; fees

S.B. 642, an Act Regarding Medical Record Copying Fees was signed into law by Governor Romney on November 26, 2003 and took effect on July 1, 2004. This bill identifies reasonable fees and establishes acceptable charges for health information that will comply with both federal HIPAA and state regulatory requirements. The term reasonable fee established under this section may be adjusted to reflect the consumer price index (CPI) for medical care services, such that the base amount and the per page charge shall be increased by the proportional CPI in effect as of October of the calendar year in which the request is made, rounded to the nearest dollar. The new fee is as follows:

A base charge of not more than (17.19) dollars for each request for a hospital or clinic medical record and; a per page charge of not more than (0.58) cents for each of the first 100 pages of a hospital or clinic medical record that is copied per request; and not more than (0.30) cents per page for each page in excess of 100 pages of a hospital or clinic medical record that is copied per request and the cost of postage and mailing.