SCCHC Medical Record #_____

South Cove Community Health Center

Request to Disclose Health Information

Patient Name (First, Middle, Last)	Date of Birth
Address	
City/State/Zip Code	Telephone #

Disclosed Information: (if not Entire Record then check each item to be released)

☐ **Entire Record** **or**
☐ Office Notes ☐ Immunization Records ☐ Medication Records
☐ Most Recent Phys. Exam ☐ Lab Reports ☐ Other: _____

Special Records:
I understand that information related to my diagnosis or treatment for AIDS/HIV, sexually transmitted disease, psychiatric care and treatment, or treatment or drug and alcohol abuse may be released as part of my health information.
I am requesting that the following information be excluded from this release:

HIV/AIDS Testing/Test results	Sexually Transmitted Disease	Psychiatric Care/Treatment	Alcohol and Drug Abuse
☐ Do not disclose	☐ Do not disclose	☐ Do not disclose	☐ Do not disclose

Information To Be Provided To:
Name of Person or Institution

Address	
City/State/Zip Code	Telephone #
Purpose/Use Of The Requested Information: ☐ Personal Use ☐ Insurance ☐ Transfer of Care ☐ Medical Treatment ☐ Legal ☐ Other _____	Fax #

Delivery Method:	Media Type:
☐ Mail ☐ Pick up at Health Center (145 South St., Boston Only) ☐ Fax (Urgent Care Only)	☐ Paper ☐ CD/USB Drive

1. I understand that South Cove Community Health Center may charge a fee related to disclosing my health information records.
2. I understand that I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing and present my written revocation to the Health Center at the address listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. This authorization will expire automatically in **six months** from the date on which it was signed or as specified: _____/_____/_____.
4. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
5. I understand authorizing the disclosure of information identified above is voluntary. I need not sign this form to ensure health care treatment.

Signature Of Patient or Personal Representative	Print Name	Date
Relationship Of Personal Representative To Patient	If Signed By Someone Other Than Patient, Please State Reason, Attach Documentation.	

Instructions:
Please complete, sign, and return this form to:
1. Fax: 617-457-6600 or
   Mail to:
   South Cove Community Health Center
   Medical Records
   145 South Street
   Boston MA 02111
2. If payment is required we will calculate and notify you of charges due.

Charges (if applicable): **SCCHC Use Only**
Base Fee: $_____
Retrieval Fee (off site storage): $_____
Copying Fee (Total Pages _____):
_____pages at 50 cents/first 100 pages $_____
_____pages at 25 cents/each additional page $_____
CD/USB Media Fee: $_____
Total Fee: $_____
Make checks payable to: South Cove Community Health Center