Hawthorn Medical Associates

Authorization to Use and Disclose Protect Health Information

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____

Any other Previous Names: _____

Patient Address: _____ Phone #'s: _____

City: _____ State: _____ Zip: _____ EMAIL: _____

Your Steward Doctor's Name that you are requesting records from: _____

I hereby Authorize Steward Medical Group to:

Please choose one: ○ Release my medical record information to ○ Obtain medical information from

Name/Facility: _____ Attention: _____

Address: _____ Phone #: _____

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

Purpose of Request: ○ Personal ○ Referral or 2nd Opinion ○ Legal ○ Insurance ○ Other _____

○ Transfer from Practice/Reason? _____.

Specific Records/Report(s) to be released:

Please do not prepay. You will be invoiced for your selection by our vendor.

○ Provide a 2 year abstract of my records. An abstract is the lesser of $ 25.00 or amount allowed by state statute, plus postage.

○ Provide a copy of my full electronic record. A full record is the lesser of $ 50.00 or amount allowed by state statute, plus postage.

○ Other - be specific, include dates and MD's under comments. You will be invoiced at the amount allowed by state statute.

***COPY FEE:** Pursuant to each respective state statute, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Massachusetts Chapter 111, Section 70; New Hampshire Chapter 332-I, Section 1*

Restricted Authorization to Release Protected Information:

STOP **IMPORTANT -** It is extremely important that you select either you "**DO**" or "**DO NOT**" for each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

Release Records? Check one

I ☐ **DO** ☐ **DO NOT** want **Mental/Behavior Health or Disability Services Provider Documentation *** released.

I ☐ **DO** ☐ **DO NOT** want **HIV/AIDS Screening Test Results** released

I ☐ **DO** ☐ **DO NOT** want information about **Alcohol and/or Substance Abuse Treatment** *** released

I ☐ **DO** ☐ **DO NOT** want **Genetic Testing/Test Results **** released

I ☐ **DO** ☐ **DO NOT** want **Confidential Communications with a Social Worker** released

I ☐ **DO** ☐ **DO NOT** want information about **Rape/Sexual Assult Victim's Counseling** released

I ☐ **DO** ☐ **DO NOT** want **Child/Elder Abuse or Neglect & Abuse of an Adult with a Disability** released

I ☐ **DO** ☐ **DO NOT** want information about **Sexually Transmitted Disease (STD's)** released

I ☐ **DO** ☐ **DO NOT** want information about **Domestic Violence Victim's Counseling** released

* This Authorization is not valid for use or disclosure of psychotherapy notes.

** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not test done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.

*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment" (42 CFR Part 2). Does not include records created or maintained by a general medical facility.

Sign Here

Date Here

Signature of Patient's **Date**

Signature of Personal Representative **Date** **Relationship to patient or authority to act for patient**

Term: This Authorization will remain in effect until Steward Medical Group (SMG) fulfills this request.

Revocation: I understand that I may revoke this Authorization at any time by requesting it of Steward Medical Group in writing at the address listed below. The revocation will be effective immediately upon Steward Medical Group's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Steward Medical Group in reliance on this Authorization before it received my written notice of revocation.
Written Notice is to be mailed to: ADDRESS INSERTED HERE

Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at Steward Medical Group

Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state Privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by SMG.

Access: I understand that in certain circumstances Steward Medical Group has the right to deny me access to all or portions of my Protected Health Information and must notify me in writing of any such denials.