Winchester Hospital

A member of Lahey Health

Authorization to Release Medical Records

*** For Office Use Only ***

MR #: _____ Acct #: _____

ID verified? Y N Req. #: _____

Patient Information: ** Please Print **

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Release / Send Information To:

I hereby authorize: ☐ Winchester Hospital ☐ Family Medical Center ☐ Other Facility: _____

To release information contained in my medical record to:

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

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

Information to be Released:

____ ED / WIUC ____ Operative Report ____ Pathology Report

____ History & Physical ____ Stress Test, PFT, Sleep Study ____ Complete Record

____ Discharge Summary ____ Lab, X-ray, EKG, EEG, EMG Other: _____

Date of Service: _____

Purpose of Request: ____ Medical ____ Legal ____ Personal ____ Insurance

Authorization to Release / Send Protected or Sensitive Information:

In order for us to release any of your medical information that may fall into the categories listed below you must initial on the line. We will not send out this information if the line is blank → **WRITE YOUR INITIALS ON THE LINE**

- Treatment information related to Psychiatric/Psychological, Domestic Violence or Sexual Assault _____
- Medications and/or Labs that are sensitive by law _____
- Drug &/or alcohol substance abuse/treatment to be released _____
- Sexually transmitted disease to be released _____
- Abortion Information _____
- Genetic Testing _____
- HIV/AIDS testing or treatment to be released _____

STOP

Please make sure you have filled out this form completely: printing your full name and date of birth, Checking the purpose of the request, checking the information to be released, and initialing ***ALL*** the protected /sensitive information categories above that may pertain to your records.

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 I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer or Director of Health Information.

I understand that I have a right to revoke this authorization; I must do so in writing and present my written revocation to the Medical Records/Health Information Management Department. 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.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.

_____	_____	_____
Signature – Attach legal documents when applicable	**Date / Time**	**Relationship, if other than patient**

Please note: There may be a charge for the copying and mailing of medical record copies.