

Authorization to Disclose Protected Health Information

1. Patient Information

Patient Full Name: _____
 Patient Address: _____ City, ST, Zip: _____
 Date of Birth: _____ Phone #: _____
 Other Name During Treatment? _____

2. Release Information To

-This Box Must Be Complete In Order For Request To Be Processed-

Name/Facility: _____ Attention: _____
 Address: _____ City, ST, Zip: _____
 Phone: _____ Fax #: _____
 Purpose of Request: Personal Treatment Legal Insurance Disability Marketing
 Transfer/Reason: _____ Other: _____

A fee will be charged for all requests going to self or for transfer of care.

3. Information to be Released

Treatment Dates: ____/____/____ to ____/____/____
 Summary Material Transcribed Reports Consultation Reports Progress Notes
 Discharge Summary Physician Orders Therapy Notes Billing Statements
 X-Ray/Diagnostic Lab Results Other: _____

Cost of copies based upon Massachusetts Law: \$18.60 Base charge and \$0.33 per page.

4. Authorization to Release Sensitive Information

Required – Please complete the check boxes and initial lines below indicating how sensitive information should be handled.

Check One

Initial each line below

I **DO** **DO NOT** **N/A** want information about **Mental Health** released _____
I **DO** **DO NOT** **N/A** want information about **HIV/AIDS Information** released _____
I **DO** **DO NOT** **N/A** want information about **Alcohol/Substance Abuse** released _____
I **DO** **DO NOT** **N/A** want information about _____ released _____

Other sensitive info

Please confirm that you have put a **checkmark** and **initialed** all the sensitive information categories above regardless if they are applicable or not. If this form is incomplete or if sensitive information is not initialed, we may be unable to fulfill this request.



- I understand this authorization expires in 90 days from the signature date appearing below unless otherwise noted in the following space: _____.
- I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do revoke, it would not have any effect on information released by the hospital before it received the revocation.
- I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Five Star Quality Care, Inc. and its affiliates is not conditioned on whether or not I sign this authorization. I know that I may refuse to sign this authorization.
- I understand that release of my information to Five Star Quality Care, Inc. or its use by Five Star Quality Care, Inc. for marketing purpose(s) may result in direct or indirect remuneration to Five Star Quality Care, Inc.

Signature _____ Date _____

(Patient/Legal Guardian)

Legal Guardian: Request is only valid if documentation is attached that validates your authority.