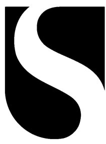

STURDY
MEMORIAL HOSPITAL

P.O. Box 2963
211 Park Street
Attleboro, MA 02703-0963
Tel. 508-222-5200

STURDY MEMORIAL HOSPITAL/MANSFIELD HEALTH CENTER
AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT:
Medical Record # ____________________________

____ ____________ ________________________
Name of Patient/Previous Names Birth Date Home Telephone

____ ____
Street Address City/State/Zip

AUTHORIZES:

____
Name of Health Care Provider/Plan/Other
____
Street Address
____
City, State, Zip Code

RELEASE OF PROTECTED HEALTH INFORMATION TO:

____
Name of Health Care Provider/Plan/Other
____
Street Address
____
City, State, Zip Code

INFORMATION TO BE RELEASED:
- ☐ Entire Record
- ☐ Complete Admission (Specify Dates)_______________
- ☐ Emergency Room (specify Dates)__________________
- ☐ SDC (Specify Dates)______________________________
- ☐ Sturdy Plus (Specify Clinic/Date(s))__________________
- ☐ Other (Specify):_________________________________
- ☐ X-Ray Reports (Specify Dates)____________________
- ☐ Lab Reports (Specify Dates)______________________
- ☐ Physical Therapy (Specify Dates)__________________
- ☐ Surgical Reports (Specify Dates)__________________
- ☐ Consultation (Specify Dates)______________________
- ☐ Inspection Only___________________________

SENSITIVE INFORMATION:
By initialing next to a category of sensitive information listed below, I specifically authorize the use and/or disclosure of the type of sensitive information indicated next to my initial which might otherwise be subject to special legal protections preventing its use or disclosure:

	(Initial)
· Information about Mental Health Communications	_______
· Information about HIV/AIDS Testing or Treatment	_______
(including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).	_______
· Information about Venereal Disease (STD)	_______
· Information about Sexual Assault	_______
· Information about Substance (i.e. alcohol or drug) Abuse	_______
· Information about Genetic Testing	_______

PURPOSE OF DISCLOSURE: (Check applicable categories)
☐ Further Medical Care ☐ Insurance Eligibility ☐ Legal Action ☐ Changing Physicians
☐ Personal ☐ Payment of Bill ☐ Other (Specify):_________________________________

I understand that once my health information is disclosed in accordance with the terms and conditions of this authorization, it cannot be guaranteed that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Refuse to Sign Authorization – I understand that I may refuse to sign this authorization and that such refusal will not affect my health care or payment for my health care that is provided at Sturdy Memorial Hospital. However, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, Sturdy Memorial Hospital may refuse to treat me if I do not sign this authorization. I have the right to see and copy the information on this form or ask for another copy of the form at anytime within six years of its expiration date.
Right to Revoke Authorization – I understand written notice is necessary to revoke this authorization. Such notice should be sent to: Sturdy Memorial Hospital, Medical Record Department/Correspondence Section, 211 Park Street, P.O. Box 2963, Attleboro, MA 02703-0963 and will immediately become effective. I am aware that revoking my authorization will not affect any information previously released with an authorization.

EXPIRATION DATE: This authorization is good until the following date(s)___________________________________
or for 90 days from the date signed.

I have had an opportunity to review and understand the content of this authorization form.
By signing this authorization, I am confirming this accurately reflects my wishes.

____ ____________________
Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signature:

____ ____________________________ _____________
Signature of Personal Representative Relationship or Authority Date

WITNESS:____

Distribution of Copies: Original to Provider; Copy to Patient; Copy to accompany use or disclosure