wheaton college massachusetts

Norton Medical Center
Authorization to Use and Disclose Protected Health Information

Patient Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ **Date of Birth**: _____

I authorize Norton Medical Center to **disclose/release information to:**	I authorize Norton Medical Center to **obtain information from:**
Name:	Name:
Address:	Address:

The type of information to be disclosed is as follows:

- o Entire medical record – may include records from other providers
- o Verbal communication between health care providers
- o Laboratory results _____ (be specific)
- o Immunization records
- o Progress notes _____ (include dates of service)
- o Consultation records
- o Radiology results
- o Psycho-educational testing
- o Information about Mental Illness
- o Information about HIV/AIDS testing or treatment (including the fact that an HIV test was ordered, performed , or reported, regardless of whether the results were positive or negative)
- o Information about Substance (i. e., alcohol or drugs) Abuse
- o Information about STD/STI
- o Information about Sexual Assault
- o Information about Child Abuse/or Abuse of an Adult with a Disability

I authorize the exchange of this information via (check all that apply):

- o mail
- o fax
- o e- mail
- o phone

I understand that I have the right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke this authorization I must do so in writing and present my written cancellation/revocation to Norton Medical Center. I understand that the cancellation/revocation will not apply to information which has already been released. Unless otherwise canceled/revoked, **this authorization will expire 4 years from this date**.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information to be disclosed. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person/organization receiving the information.

If I have questions about the disclosure or use of my protected health information, I may contact Susan Marcil, Practice Manager, Norton Medical Center, by mail at 14 Taunton Avenue, Norton, MA 02766, or by telephone at (508) 285-9500.

My signature below indicates that I have read and understand the terms of this Authorization and I voluntarily authorize NMC to use or disclose my health information in the manner described.

Signature of Patient: _____ Date: _____

Print legal name of Patient: _____

If the patient is a minor or otherwise unable to sign this Authorization:

Signature of Personal Representative: _____

Relationship to Patient: _____ Date: _____