AUTHORIZATION TO RELEASE HEALTH INFORMATION

NORTON MEDICAL CENTER
14 TAUNTON AVENUE
NORTON, MA 02766
Phone: 508-285-9500 Fax: 508-285-3388

Norton Medical Center (dba Sturdy Memorial Associates), Wheaton's designated health clinic, is a private neighborhood facility located on-campus and owned and operated by Sturdy Memorial Hospital. Norton Medical Center is a separate entity from the college and medical information generated from student visits there is not shared with college administration (except for Valerie Tobia, Director of Counseling and Health Services) without a signed release.

This release pertains *only* to medical information documented as a result of services rendered at Norton Medical Center.

____________________	____________________	____________________
Name of Patient	Date of Birth	Telephone Number

____________________	____________________
Street Address	City/State/Zip

AUTHORIZES THE RELEASE OF PROTECTED HEALTH INFORMATION:

TO____________________________________
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

Fax: ____________________________________

Phone: ____________________________________

FROM____________________________________
Name of Health Care Provider/Plan/Other

____
Street Address

____
City, State, Zip Code

Fax: ____________________________________

Phone: ____________________________________

INFORMATION TO BE RELEASED:

Entire Record ______________________________
Surgical Reports (specific dates) _______________
Lab Reports (specific dates) ___________________
Consultation (specific dates) ______________________
Physical Therapy (specific dates) __________________
X-Ray Reports (specific dates) ___________________
Other (specify) ____

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 legal protections preventing its use or disclosure:

- 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 Sexually Transmitted Diseases __________
- Information about Sexual Assault __________
- Information about Substance (i.e. alcohol or drug) Abuse __________
- Information about Genetic Testing __________

PURPOSE OF DISCLOSURE:

Further Medical Care_______Insurance Eligibility_______Legal Action_______Changing Physicians _____________
Personal___________ Payment of Bill__________ Other (specify) ____________________________________
Permission to speak to ____

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 law 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 Norton Medical Center. However, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization, Norton Medical Center 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 signed 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: Norton Medical Center/Medical Records, 14 Taunton Avenue, Norton, MA 02766 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 below.

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: ____