

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

➤ **Patient Name:** _____ **DOB:** ___/___/___

I hereby authorize the **Berkshire Medical Center / Fairview Hospital Medical Record Department** or other entity: _____ to disclose or permit use of health information, as described below, concerning the above named individual. I understand that federal and state law offer special protection for information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or the human immunodeficiency virus (HIV). Similar protections exist for information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that, if the health information covered by this authorization contains such information, I am waiving those protections in this instance by voluntarily authorizing use or disclosure of the health information.

➤ **Date(s) of service:** _____

➤ **Type of visit:** Inpatient Emergency Department Outpatient (please specify) _____ Home Care

➤ **The type of information to be used or disclosed is as follows**
(Check the appropriate boxes and include other information where indicated)

History & Physical Discharge Summary Labs/ Pathology Radiology (X-ray, CT, MRI) Operative Report

Emergency Department Consultation Reports (physician's name) _____ Other (specify) _____

Electronic Patient Clinical Summary

Abstract (includes operative report, discharge summary, H & P, Consults, labs, x-rays, pathology, ER (if applicable))

Entire Record (charge .74 per page for first one hundred pages then .38 for each additional page)

➤ **The information above may be disclosed to or used by the following individuals or organization(s)**

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

➤ **Purpose of Disclosure:**

Medical Treatment Personal Insurance Billing Attorney Other (please describe) _____

I understand that I have a right to revoke this authorization at any time. Unless I specify differently however, this authorization will expire in 90 days from the date below. I understand that if I revoke this authorization before the 90-day expiration, I must do so in writing and present my written revocation to the Medical Record 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.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. However, any information released covered under Federal Regulation 42CFR Part 2 may not be redisclosed without my specific written consent.

I understand that I may refuse to sign this authorization and that my treatment or payment for my treatment will not be affected if I do not sign this form unless my treatment includes research or the reason for my treatment is to disclose information to another person.

I understand that I have the right, upon my request, to inspect the information to be disclosed. I am also entitled to a copy of this completed form.

I understand that Massachusetts law allows a fee to be charged for producing a copy of these records.

➤ **Please sign:**

Signature of patient or legal representative _____ Date _____

(If signed by legal representative, state relationship to patient (provide a statement of authority to act on behalf of the individual))

Signature of witness _____ Date _____

Identification verified - Signature of Employee _____

NOTE: All requests for medical treatment purposes may take from 14-21 days for processing.

FAX: (413) 346-6739

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| Berkshire Medical Center Medical Records Department 725 North Street Pittsfield, MA 01201 |
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