QUABBIN VALLEY EYE CARE

1448 N. Main St., Palmer, MA 01069 ◦ Phone: (413)-283-2946 ◦ Fax: (413)-283-3631

Authorization for the Disclosure of Protected Health Care Information

Patient Name:_____ Date of Birth:_____
Address:_____ Phone Number:_____

INFORMATION TO BE RELEASED BY Quabbin Valley Eye Care TO:	INFORMATION TO BE RELEASED TO Quabbin Valley Eye Care FROM:
Organization/ Person Name:_____	Organization/ Person Name:_____
Street Address:_____	Street Address:_____
City, State, Zip:_____	City, State, Zip:_____
Phone/Fax:_____	Phone/Fax:_____

TYPE OF MEDICAL RECORDS REQUESTED:

- ☐ Most recent date of service
- ☐ Complete medical record abstract (includes 3 years of chart notes, most recent tests & diagnostic imaging reports)
- ☐ My health information only for the following date(s):_____
- ☐ Diagnostic imaging/photos only
- ☐ Other:_____

SENSITIVE INFORMATION: This authorization includes the release of the following sensitive information unless specifically excluded. Please circle if you do not want this released:

Mental Health HIV/AIDS Sexually Transmitted Diseases Drug & Alcohol Treatment

REASON FOR REQUEST:

- ☐ Personal/At the Request of the Patient
- ☐ Transfer of Care
- ☐ Disability Insurance
- ☐ Other (please explain):_____

PATIENT RIGHTS:

- I understand this authorization is voluntary and expires in 90 days from the date it is signed. I do not have to sign this authorization to receive health care benefits (treatment, payment or enrollment)
- There may be a fee for paper copies of the records requested (at a cost of $0.30 per page, not to exceed $25 per patient per request). Records sent electronically through a secure connection will incur no additional fees.
- I understand that it may take up to 14 business days for records to be processed and released
- Disclosure of documents creates the potential for unauthorized re-disclosure. I release Quabbin Valley Eye Care, it's staff and providers from any legal liability in connection with re-disclosure of this information
- I may revoke this authorization, in writing, at any time. Revocation does not apply to information already released in response to this authorization. Revocation of this authorization does not apply to my insurance company, where law provides the insurer the right to contest a claim under my policy

_____

Patient or Legally Authorized Individual Signature Date

_____

Printed Name Relationship