# Cooley Dickinson Hospital

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

CDH 299 Rev. 9/20/11

Medical Record #_____

**PATIENT FULL NAME**: (please print)_____

**DATE OF BIRTH**: _____ **PHONE**: _____ **CELL PHONE:** _____

**INFORMATION REQUESTED**:

Dates of treatment: _____

☐ Summary ☐ X-ray, CT, MRI reports (**not films**) ☐ Laboratory results ☐ Entire record

☐Rehab: ☐ OT ☐ PT ☐ Speech-Language

☐ Other [please specify] _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse_____ (initial).

**PERSON/FACILITY TO RECEIVE INFORMATION (REQUIRED):** PLEASE WRITE CLEARLY

**(NAME & ADDRESS)** _____ _____

_____ FAX#_____

_____ **EMAIL** _____

For electronic delivery of records

_____ **Phone#**_____

**** REQUIRED if different than patient's phone #**

**I authorize Cooley Dickinson Hospital to release the information specified above.** I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure. I understand that I have a right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing. 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. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify and expiration date, event or condition, this authorization will expire in six (6) months. I understand that my treatment or continued treatment by CDH is in no way conditioned on whether or not I sign this authorization, and that I may refuse to sign it.

Cooley Dickinson Hospital has the right to **CHARGE A PHOTOCOPY FEE of $0.67 PER PAGE** for all photocopy requests, as well as postage fees. If you are requesting this for follow-up medical care, please allow us to send it directly to your healthcare provider at no charge. Requesting a 'summary' rather than the entire record will significantly reduce this cost. Bills for this service will be processed by Healthport. Records will not be photocopied until payment for this service has been made.

_____ _____

**Signature of Patient or Legal Representative** **Date**

If signed by legal representative, relationship to patient: _____ Printed name _____

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**DEPARTMENT USE ONLY**

**PROCESSED BY:** _____ **ID CHECKED BY:**_____ **MAIL FAX PICKUP EMAIL**

**DATE PROCESSED:** _____ **(CIRCLE ONE)**