|  |  |  |
| --- | --- | --- |
|  |  |  |
| American Chinese Medical Center, P.C.Howard H. Liu, MD |
| **Mail or Fax Release of Information To:****1842 Beacon Street, Suite 302. Brookline, MA 02446****Phone: 617.734.7333 Fax: 617.734.1500** |

**Authorization for Release of Protected or Privileged Health Information**

Please print all information clearly in order to process your request in a timely manner

|  |
| --- |
| **A. PATIENT INFORMATION** |
| PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PATIENT ADDRESS: APT. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_\_\_\_ ZIP CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TELEPHONE CONTACT #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

|  |
| --- |
| **B. PERMISSION TO SHARE:** I give my permission to share my protected health information. Enter where you would like information sent from and to whom you would like the information sent.  |
| **From:** (e.g. hospital, clinic or provider name)Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PURPOSE: (check the appropriate box)󠄀 Medical care 󠄀 󠄀 󠄀󠄀 Personal\*󠄀 Insurance\* 󠄀󠄀 School󠄀 Legal Matter\* 󠄀󠄀 Other (please specify)\* \*Copying fees may apply \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | **To:** (e.g. to whom you would like the information sent)Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Tel # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEND BY:󠄀 Paper copy via Mail󠄀 Fax: 󠄀(provide fax number)  |

|  |
| --- |
| **C. INFORMATION TO BE RELEASE:** (Please check all apply and specify dates) |
| 󠄀 Complete records/dates 󠄀󠄀 Immunization record/dates 󠄀󠄀 X ray/dates 󠄀 󠄀󠄀 Lab reports/dates 󠄀 󠄀󠄀 Office notes/dates 󠄀󠄀 Mammograms/dates 󠄀󠄀 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates to release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **Pleases check to indicate if you do not give permission the following information if present in your record:****󠄀 HIV test result/dates 󠄀󠄀 Alcohol and Drug Abuse Records/dates 󠄀󠄀 Details of Mental Health/dates 󠄀** **󠄀 Other /dates Date to release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

|  |
| --- |
| This Authorization is voluntary. This facility, American Chinese Medical Center, P.C., (A.C.M.C) cannot control how the recipient uses or share the information. And that laws protecting its confidentiality at A.C.M.C. may or may not protect this information once it has been released to the recipient. This authorization will automatically expire **6 months from the date signed** unless otherwise specified. |

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_