Berkshire Health Systems

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

AREAS THAT HAVE A ►NEXT TO IT MUST BE COMPLETED

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

I hereby authorize the **Berkshire Medical Center / Fairview Hospital / Berkshire Faculty Services 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 visit:** _____

►**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)_____

☐ Abstract (includes operative report, discharge summary, History & Physical, Consults, labs, x-rays, pathology, ER (if applicable))

☐ Entire Record. Rates are compliant with current Massachusetts General Laws and Federal Regulations.

Who do you want to receive this information:

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

Name: _____Phone:_____

Address: _____City:_____State:_____ Zip:_____

☐ Fax to: _____ ☐ Pick up ☐ Mail

►**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) 553-6739

Berkshire Medical Center
Medical Records Department
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