Trinity Health
Of New England
Medical Group

Authorization For Use or Disclosure of Medical Record Information

Return Completed Forms to:

Connecticut - to your Local Practice
Massachusetts - Fax to (413) 782-4047

Medical Record #:

Form Reviewed By:_____

Patient Information

Patient Name (Please Print): _____ Date of Birth: _____
Patient Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Email: _____
Name of Insurance Plan: _____

I hereby Authorize Trinity Health Of New England Medical Group:

Please choose one: ○ Release my medical record information to ○ Obtain medical information from

Name/Facility: _____ Attention: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: ○ Personal ○ Referral ○ Legal ○ Insurance ○ Other _____
○ Transfer from Practice/Reason? _____.

Specific Records to be released:

○ Please provide me with a 2 year abstract of my medical records.
○ Please provide me with a copy of my entire medical record.
○ Please provide the specific information as outlined below:

_____ Date(s) of Treatment _____
_____ Date(s) of Treatment _____
_____ Date(s) of Treatment _____

Charges for medical copies are governed by both state and federal regulations. The rates Sharecare will charge are calculated based on the HIPAA cost-based fees (which allows for the charging of medical record copies) or state statute...whichever is less. Delivery costs (if applicable) are also charged.

STOP

IMPORTANT - It is extremely important that you select either **YES** or **NO** and **Initial** each item contained in this section *Authorization to Release Protected Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

	Yes	or	No	Initial
> HIV Testing	☐		☐	_____
> Allied Mental Health and Human Services Professional communications	☐		☐	_____
> Genetic Testing	☐		☐	_____
> Psychologist and Social Worker communications	☐		☐	_____
> Substance Abuse	☐		☐	_____
> Sexually Transmitted Diseases	☐		☐	_____

Term: This Authorization will remain in effect until Trinity Health Of New England Medical Group fulfills this request. **Revocation:** I understand that I may revoke this Authorization at any time by requesting it of Trinity Health Of New England Medical Group in writing at the address listed below. The revocation will be effective immediately upon Trinity Health Of New England Medical Group receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Trinity Health Of New England Medical Group in reliance on this Authorization before it received my written notice of revocation.

Written Notice is to be mailed to: **Health Information Management Department, 444 Montgomery Street, Chicopee, MA 01020**

Effect on Treatment: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation, quality or payment for such treatment at Trinity Health Of New England Medical Group.

Potential for Redisclosure: I understand the person receiving my Protected Health Information may not be required to comply with federal & state Privacy laws & my Protected Health Information may no longer be protected by the applicable state & federal law once it is disclosed by Trinity Health Of New England Medical Group.

Sign Here _____ Date _____

Signature of Patient **Date**

Signature of Personal Representative **Authority to act for patient** **Date**