

**Authorization For Use or Disclosure of
Medical Record Information**

Medical Record #:

- 230 Main Street Agawam, MA 01001 444 Montgomery Street Chicopee, MA 01020 305 Bicentennial Hwy Springfield, MA 01118 1029 North Road Westfield, MA 01085 70 Post Office Park Wilbraham, MA 01095

Patient Information

Patient Full Name: _____ Date of Birth: _____
 Patient Address: _____ Home Phone: _____
 City: _____ State _____ Zip: _____ Work Phone: _____

Release of Information I hereby Authorize RiverBend Medical Group to:

Mail Copies of my Medical Information to: _____ Hold for Patient Pick-up Discuss Medical Record Information With: _____ To obtain my individually identifiable health records from: _____

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

Purpose of Request: Personal Continuing Care Legal Insurance Other _____

COPY FEE: Pursuant to Chapter 135 of the Acts of 2003, "An Act Establishing Reasonable Fees for Copying Medical Records", Mass. Gen. L. ch. 11, §70, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Note - RiverBend Medical Group is "capping the fee at \$25 for a two-year abstract of your record". If you want the entire medical record, or more than the two-year abstract, please reference the RiverBend Medical Group website at www.riverbendmedical.com for current Massachusetts state copy fees.

Information to be Released PLEASE BE SPECIFIC - include dates of treatment & provider name if applicable.


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

Authorization for Release of Statutorily Protected (sensitive) Information

DO NOT Leave This Section Blank - The requested medical record MAY or MAY NOT contain information that is statutorily protected. You must check either "Yes" or "No" and initial each category for RiverBend Medical Group to properly process your medical record request.

Do you authorize Riverbend Medical Group to release the following medical information? Check "yes" or "no".

	Yes	or	No	Initial Here:
Mental Health	<input type="checkbox"/>		<input type="checkbox"/>	_____
HIV Tests & Related Information	<input type="checkbox"/>		<input type="checkbox"/>	_____
Alcohol and/or Substance Abuse	<input type="checkbox"/>		<input type="checkbox"/>	_____
Abortion	<input type="checkbox"/>		<input type="checkbox"/>	_____
Sexually Transmitted Disease	<input type="checkbox"/>		<input type="checkbox"/>	_____
AIDS/ARC	<input type="checkbox"/>		<input type="checkbox"/>	_____
Genetic	<input type="checkbox"/>		<input type="checkbox"/>	_____
Domestic Sexual Assault	<input type="checkbox"/>		<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>		<input type="checkbox"/>	_____

 Please confirm that you have checked "Yes" or "No" and initialed all protected information categories above even if they do not necessarily apply to the patient's records. If information is not released and/or form is incomplete, RiverBend Medical Group may be **unable to fulfill this request**.

Sign Here →

→ **Date Here**

 Patient's Signature Date*

 Parent/Legally Recognized Representative Signature** Date*

 Witness Date

**Know Your
Privacy Right**
refer to the HIPAA
**"PRIVACY
NOTICE"**

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify other wise: _____. You may revoke this Authorization at any time by providing a written statement to the Health Information Management Department, except to the extent that RiverBend has already completed action on it.

** By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: _____
 The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. RiverBend will not condition treatment on payment of the provision of this Authorization.