

## 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    
  395 Southampton 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:
<input type="checkbox"/> Mail Copies of my Medical Information to: <input type="checkbox"/> Hold for Patient Pick-up <input type="checkbox"/> Discuss Medical Record Information With: <input type="checkbox"/> To obtain my individually identifiable health records from:	
Name/Facility: _____ Attention: _____	
Address: _____ Phone: _____	
City: _____ State _____ Zip: _____ Fax: _____	
Purpose of Request: <input type="radio"/> Personal <input type="radio"/> Continuing Care <input type="radio"/> Legal <input type="radio"/> Insurance <input type="radio"/> Other _____	
<b>COPY FEE:</b> 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 <a href="http://www.riverbendmedical.com">www.riverbendmedical.com</a> for current Massachusetts state copy fees.	

Information to be Released	<b>PLEASE BE SPECIFIC</b> - 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	
<b>DO NOT Leave This Section Blank</b> - 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 <b>RiverBend Medical Group</b> to properly process your medical record request.	
Do you authorize Riverbend Medical Group to release the following medical information? Check "yes" or "no".	
	<b>Yes</b> or <b>No</b>
Mental Health	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
HIV Tests & Related Information	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
Alcohol and/or Substance Abuse	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
Abortion	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
Sexually Transmitted Disease	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
AIDS/ARC	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
Genetic	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
Domestic Sexual Assault	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
Other _____	<input type="checkbox"/> <input type="checkbox"/> Initial Here: _____
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 <b>unable to fulfill this request</b> .	

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.