ARBOUR-FULLER
HOSPITAL
A Division Of Arbour Health System
200 May Street
South Attleboro, MA 02703-5515
(508) 761-8500/FAX (508) 761-4240

AUTHORIZATION TO OBTAIN/RELEASE OF INFORMATION FORM

Patient: _____Date of Birth_____

Patient's Address:_____

I hereby authorize Arbour-Fuller Hospital to: ☐ Obtain From **AND/OR** ☐ Release To

Facility: _____

Address: _____

ATTN: _____ **Fax # (if applicable):**_____

The following information contained in the medical record of the above named patient pertaining to services provided on or about_____. Please check the appropriate information to be released:

☐ Admission Note
☐ Discharge Summary
☐ Physical Examination
☐ Medical Consult
☐ Psychological Testing
☐ Laboratory Data
☐ Treatment Plans
☐ Other (please be specific) _____
☐ Rehab Assessments
☐ Aftercare Plan

The information is needed for the following purpose(s) and may not be redisclosed:
☐ To provide ongoing treatment/aftercare.
☐ Other: _____

I understand that records which refer to treatment of diagnosis of drug or substance abuse are protected under the Federal Regulations (42CFR, Part 2), Confidentiality of Alcohol and Drug Abuse Treatment.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or psychiatric records including alcohol and drug abuse records, if applicable, to those persons/agencies named above.

I further release the Hospital and its employees from any liability arising from the release of this information to such persons/agencies, provided said release of information is done substantially in accordance with applicable law.

This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder.
Once the requested PHI is disclosed, the Privacy Regulations may no longer protect it if the PHI's recipient rediscloses it.

I understand this consent is subject to revocation at any time unless action based on it has already begun. This authorization will automatically expire 90 days from the date it is signed.

My records ☐ may ☐ may not be faxed. _____(please initial).

_____ _____ Date: _____
Signature of Patient/Legal Guardian or Parent if Patient is Under 18 — Relationship to Patient

Witness: _____ Adolescent Signature : _____

AUTHORIZATION to RELEASE H.I.V. INFORMATION

I hereby specifically authorize the release of HIV antibody or antigen testing or records containing HIV, HIV virus or any AIDS related conditions which may be contained in the above referenced request.
SIGNATURE: _____ DATE: _____