AUTHORIZATION OF MILFORD REGIONAL MEDICAL CENTER TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name: _____
Last **First** **Middle**

Home Address: _____

_____

Home Telephone: _____ **Date of Birth:** _____

SPECIFY INFORMATION TO BE DISCLOSED: The information that may be disclosed under this Authorization includes: _____

_____

_____

_____

MY HIGHLY CONFIDENTIAL INFORMATION:
Without limiting the information specified above, by checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Psychotherapy notes of a mental health professional
- ☐ Information about mental health or developmental disability services
- ☐ Alcohol/drug abuse treatment program records and information
- ☐ HIV/AIDS test results
- ☐ Domestic abuse
- ☐ Sexual abuse
- ☐ Abortion
- ☐ Sexually Transmitted Diseases
- ☐ Genetic Testing
- ☐ Other: _____

RECIPIENT: Name of person or class of persons to whom Milford Regional Medical Center (the "Company") may disclose my health information:

_____

_____

_____

Address of the recipient or where my health information should be delivered:

_____

_____

TERM: This Authorization will remain in effect:

- ☐ From the date of this Authorization until _____ __, 20__
- ☐ Until Company fulfills this request
- ☐ Until the following event occurs: _____

PURPOSE: I authorize the Company to use or disclose my health information (including the highly confidential information I selected above, if any) during the term of this Authorization for the following specific purpose(s): _____

_____

I understand that once Company discloses my health information to the recipient, Company cannot guarantee that the recipient will not re-disclose my health information to a third party. Further, the third party may not be required to abide by this Authorization or applicable federal law governing the use and disclosure of my health information. However, if my information includes alcohol or drug abuse treatment program records or information, the confidentiality of the records or information is protected by federal law (42 C.F.R. Part 2) that prohibits re-disclosure except with my specific written consent.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at the Company; except, however, if my treatment at the Company is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Company may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Company's Privacy Office at the address listed below. The revocation will be effective immediately upon the Company's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Company in reliance on this Authorization before it received my written notice of revocation.

I may contact the Company's Privacy Office by mail at Milford Regional Medical Center, 14 Prospect Street, Milford, MA 01757, by telephone at (508) 422-2483, or by email at lrousseau@milreg.org.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature, I hereby, knowingly and voluntarily, authorize the Company to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient **Date**

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date

A fee may be charged for records within the guidelines of HIPAA and the State of Massachusetts.

Form #170
Revised: 3/2017