Hallmark Health Corporation
Authorization to Disclose Protected Health Information
Lawrence Memorial Hospital FAX (781) 306-6818
Melrose-Wakefield Hospital FAX (781) 979-3197

PATIENT NAME:____Phone #__________________________

ADDRESS: ____

DATE OF BIRTH: ____ ________________________________

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. I authorize Hallmark Health Corporation to disclose my Protected Health Information as described below to the following individuals/organization:

____

3. For the purpose of: ____

4. The type and amount of information to be used or disclosed is as follows:

_______Discharge summary   _______ER report   ________ Pertinent information
_______Operative Report   _______Lab, X-ray   ________Entire medical record

Other:____

5. I understand that I have a right to revoke this authorization at anytime. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HHC Corporation from which this disclosure is sought. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

____**Expiration Date/Event**

If I fail to specify an expiration date, event or condition, this authorization will only be used once to disclose my medical/billing records to the above-mentioned requestor.

6. I understand that authorizing the disclosure of this Protected Health Information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Official at the corporation where I have authorized disclosure.

7. Limitations To Disclosure (If any):____

8. Proof of Legal Representation: If this authorization is signed by some person other than the patient (except in cases where the patient is 17 years old or younger and the requestor is the parent of an unemancipated minor), I understand that I must provide written proof of legal representation prior to HHC disclosing any Protected Health Information (e.g. Provide proof of executorship, guardianship, etc).

*********************************SIGNATURE LINE BELOW******************************

9. I have read this form and agree to the disclosure of all Protected Health Information regarding my treatment including but not limited to: Psychiatric treatment or testing (I understand I must complete a separate form to authorize the disclosure of psychotherapy notes which are not the same as psychiatric treatment or testing), treatment for drug and/or alcohol abuse or use, abortion, treatment for sexually transmitted disease, adoption, social service notes and any other information contained in my record unless I describe other limitations to disclosure in Section 9 of this authorization.

Please Sign Here____

Patient/Legal Representative Date

10. I understand that the information in my medical record contains information relating to AIDS (Acquired Immunodeficiency Syndrome) or HIV(Human Immunodeficiency Virus) treatment or testing and I authorize its disclosure.

Please Sign Here (if appropriate)____

Patient/Legal Representative Date