



10136

Care New England

FOR INPATIENTS: AFFIX PATIENT LABEL OR
WRITE IN BOTH PATIENT NAME & MR NUMBER

FOR OUTPATIENTS: WRITE IN BOTH PT NAME & DOB

PATIENT NAME: _____

DOB OR MR # _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

10136 (3-2015)

1 Patient name: _____ ("Patient") Date of Birth: _____ Telephone: _____
 Address: _____ Med. Rec. # _____
 Street City State Zip

2. The undersigned hereby authorizes the following CNE Provider _____
 (Insert Hospital/Facility/Physician name) (the "Provider")

Address: _____
 Street City State Zip
 Telephone: _____ Fax: _____

to release/disclose to the individual and/or entity named in Section 3 ("Recipient")
AND/OR

to request/receive from the individual and/or entity named in Section 3 ("Disclosing Party")
 the protected health information ("Health Information") specified in Section 4

3. Recipient or Disclosing Party: _____ (Insert Individual/Entity Name)
 Telephone: _____ Fax Number (if Health Information is to be faxed): _____
 Address: _____
 Street City State Zip

4. Please check one or more types of Health Information to be released/requested:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Laboratory Results	<input type="checkbox"/> Operative Report
<input type="checkbox"/> Immunization Records	<input type="checkbox"/> X-Ray/Imaging Results	<input type="checkbox"/> Psychiatric Exam
<input type="checkbox"/> Emergency Dept. Records**	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Psychological Tests
<input type="checkbox"/> Registration Record	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Treatment Plan(s)
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Entire Record

OTHER (Please specify): _____
****An authorization for Emergency Department Records may include any of the above listed Health Information records.**

5. Time frame for which the Health Information authorized in Section 4 above should be released/requested:
 For the period from _____ (insert start date) through _____ (insert end date);
OR ALL DATES OF TREATMENT _____ (Please initial)

6. The undersigned acknowledges, agrees, and understands that unless specifically limited below, any Health Information released may include mental health treatment information, alcohol and substance abuse treatment information, STDs and/or HIV/AIDS-related information.
DO NOT RELEASE THE FOLLOWING HEALTH INFORMATION (Please specify) _____

7. This authorization is being requested by the undersigned for the following purpose(s) (initial all that apply)
 Medical Care Legal Insurance Personal
 Other (Please describe): _____

8. The undersigned acknowledges and understands each of the following:

- authorizing the release of the Patient's Health Information is voluntary;
- refusal to sign this authorization does not affect the Patient's treatment, payment of claims, health plan enrollment or eligibility for benefits;
- this authorization may be revoked at any time upon written request to the Provider's privacy officer or health information department except to the extent that release of Patient's Health Information has already occurred in reliance on this authorization;
- unless previously revoked, this authorization will automatically expire SIX (6) months from the date of signature below;
- **any information released to the Recipient may be re-disclosed and may no longer be protected by federal or state privacy and or confidentiality laws.**

THE UNDERSIGNED (1) HAS READ AND UNDERSTANDS THIS AUTHORIZATION; (2) HAS HAD ANY QUESTIONS WITH RESPECT TO THIS AUTHORIZATION EXPLAINED TO HIS/HER SATISFACTION; (3) IS AUTHORIZED TO SIGN THIS AUTHORIZATION INDIVIDUALLY AS THE PATIENT OR AS THE PATIENT'S LEGAL REPRESENTATIVE; AND (4) HEREBY EXPRESSLY AND VOLUNTARILY AUTHORIZES THE RELEASE/REQUEST OF THE PATIENT'S HEALTH INFORMATION AS SPECIFIED ABOVE.

 Signature of Patient or Legal Representative of Patient Date/Time

 PRINT name of Patient or Legal Representative of Patient Relationship to Patient or Authority to Act for Patient

WITNESS