PATIENT REQUEST AND AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby request and authorize _____ to use
(Name of hospital/physician)
or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient name:** _____ **Date of Birth:** _____

Address: _____
Street City State Zip

3. **Information to be disclosed to:**

If there is any charge for providing the above-referenced materials, please enclose your bill when sending the materials to this office*.

4. **Disclose the following information for treatment dates:** _____ **to** _____

☐ Complete Records	☐ Consult	☐ Physical Therapy
☐ Abstract	☐ Outpatient Reports	☐ Emergency Reports
☐ Face Sheet	☐ X-Ray	☐ Itemized Bill
☐ Discharge Summary	☐ Laboratory	☐ Other Specified_____
☐ History & Physical	☐ Pathology	_____

5. ☐ **Electronic Health Records in electronic format only** (HITECH Act, 42 USCA §17935(e)(1)-see Notice on reverse)

6. **The above information is disclosed for the following purposes:**
☐ **Medical Care** ■ **Legal** ☐ **Insurance** ☐ **Personal** ☐ **Other**_____

7. I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

8. **This authorization expires on [upon]**_____

_____ _____
9. Signature of Patient or Legal Representative 10. Date

_____ _____
11. Printed name of patient or patients representative 12. Relationship to patient or authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED.

*As of March 21, 1991, health care providers, including but not limited to physicians, surgeons, chiropractors, dentists and nurses are required by Massachusetts law, M.G.L.ch.112, section 12CC, to provide at reasonable cost, a copy of the patient's record to the patient or his/her authorized representative. A charge in excess of 0.50/page for the first 100 pages, 0.25/page thereafter and a base fee in excess of $15.00 (adjusted to reflect the consumer price index) is considered excessive by the Massachusetts Board of Registration in Medicine, M.G.L. ch. 111, sec. 70.

NOTICE REGARDING OUR REQUEST FOR ELECTRONIC HEALTH RECORDS

Please be advised that this firm represents the above-named patient of yours, and as indicated on the signed HIPAA-compliant Patient Request and Authorization (see reverse side), you have been requested by and authorized by the patient to produce the patient's medical records to me. Pursuant to the HITECH Act, 42 U.S.C.A. §17935(e)(1), and its implementing regulations, 45 CFR 164.524(c)(4)(i), the patient is requesting, **in an electronic format only**, a complete copy of the patient's medical records for the stated time period. (Although the patient is making this request, please be aware that the HITECH Act applies to requests by third-parties, such as our law firm, in the same manner as it applies to requests by patients, through the following language: "If requested by an individual, a covered entity must transmit the copy of protected health information directly to another person designated by the individual." See Federal Register, January 25, 2013, Vol. 78 No. 17, Page 5634.)

The requested records should include, **but not be limited to**, any Ambulance Run Reports; Hospital Admission Face Sheet; Emergency Department Records; Discharge Summary; Admission History and Physical; Progress Notes; Orders; Consultation(s); Radiology Reports; Lab Values; Graphic Vital Signs; Anesthesia Records; Operative Report(s) and Notes; Pathology Report(s); Recovery Room Records; Nurses' Notes; Medication Records; Outpatient Records; Special Diagnostic Tests; Fetal Strips; Medical Examiner Report; and/or Certificate of Death.

The patient is not requesting paper copies; accordingly, please do **not bill us on behalf of the patient for paper copies**. **The HITECH Act and its regulations do not allow you to bill for paper copies when an electronic copy has been requested.** Please be advised that a complaint with the Department of Health & Human Services (HHS) may be filed by the patient if your facility violates the applicable federal law by improperly applying the paper copy rate for electronic records.

If any of the above records are available only as paper copies, and/or have never been collated into an electronic format, please identify the record and provide the cost of copying BEFORE sending the records. Again, if electronic health records are available, your facility must comply with the provisions of the HITECH Act.