



## Community Health Center of Cape Cod Authorization for Release of Information

Please complete form thoroughly. Your medical records cannot be released until this form is completed and signed by the patient or legal guardian. There may be a fee associated with this request.

<b>Step 1</b> Completed <input type="checkbox"/>	<b>STEP 1: Information about you:</b> <b>PATIENT NAME:</b> _____ <b>DATE OF BIRTH:</b> _____ <div style="display: flex; justify-content: space-around; width: 80%; margin: 0 auto;"> <span>Last</span> <span>First</span> </div> <b>ADDRESS:</b> _____ <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <span>Street</span> <span>City</span> <span>State</span> <span>Zip</span> </div>
<b>Step 2</b> Completed <input type="checkbox"/>	<b>STEP 2: Reason for requesting your medical records (please check one):</b> <input type="checkbox"/> CHANGING TO NEW PRIMARY CARE PROVIDER <input type="checkbox"/> COMMUNICATION with another provider <input type="checkbox"/> OTHER (Please explain) _____
<b>Step 3</b> Completed <input type="checkbox"/>	<b>STEP 3: Who has the records now?</b> <i>I hereby authorize and request: (please check one)</i> <input type="checkbox"/> _____ <input type="checkbox"/> Community Health Center of Cape Cod <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <div style="width: 45%;"> <p>Name of MD/Hospital/Clinic _____</p> <p>Street address _____</p> <p>City, State, Zip _____</p> <p>Tel/Fax _____</p> </div> <div style="width: 45%; text-align: center;"> <p>107 Commercial Street Mashpee, MA 02649 Tel 508-477-7090 Fax 508-477-7028</p> </div> </div>
<b>Step 4</b> Completed <input type="checkbox"/>	<b>STEP 4: What records do you wish to release?</b> <i>to release the following information: (please check one)</i> <input type="checkbox"/> Entire medical record <input type="checkbox"/> Dates of treatment: _____ TO _____ <input type="checkbox"/> Other (please specify) _____
<b>Step 5</b> Completed <input type="checkbox"/>	<b>STEP 5: To whom do you wish to release your records?</b> <i>to: (please check one)</i> <input type="checkbox"/> _____ <input type="checkbox"/> Community Health Center of Cape Cod <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <div style="width: 45%;"> <p>Name _____</p> <p>Street address _____</p> <p>City, State, Zip _____</p> <p>Tel/Fax _____</p> </div> <div style="width: 45%; text-align: center;"> <p>107 Commercial Street Mashpee, MA 02649 Tel 508-477-7090 Fax 508-477-7028</p> </div> </div>
<b>Step 6</b> Completed <input type="checkbox"/>	<b>STEP 6: Your signature:</b> <i>I acknowledge that I have read this document in its entirety and that I understand it. I further acknowledge that I may revoke this authorization upon written request. This authorization will remain in effect for 6 months from date of signature. I understand that any of my previous medical records received by Community Health Center of Cape Cod may be destroyed at the discretion of my provider.</i>  <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <div style="width: 45%;"> <p>_____ Patient Signature</p> <p>_____ Witness Signature</p> </div> <div style="width: 45%;"> <p>_____ Parent/Guardian Signature</p> <p>_____ Date</p> </div> </div>
<b>Step 7</b> Completed <input type="checkbox"/>	<b>STEP 7: Release of sensitive information:</b> <i>I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, HIV (AIDS) treatment and testing, social service, sexual assault, abuse and/or neglect, genetic testing, and/or sensitive information, I agree to its release.</i>  <div style="display: flex; justify-content: space-between; width: 80%; margin: 0 auto;"> <p>_____ Signature of Patient or Legal Guardian</p> <p>_____ Date</p> </div>