WPI Health Services
100 Institute Road
Worcester, MA 01609
(Phone) 508.831.5520
(Fax) 508.831.5953

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information (Please print)

First Name:	Middle Name:	Last Name:
Street Address:		
City:	State:	Zip Code:
Date of Birth:	Phone:	Email (optional):

What records do you want? (Check appropriate boxes below):

Date(s) of service: _____/_____/_____ through _____/_____/_____

- ☐ Entire Visit From Date(s) Listed Above
- ☐ Discharge Summary
- ☐ Emergency Room Records
- ☐ Test Results (X-rays, Lab/Pathology Results). Please specify: _____
- ☐ Other (Immunization Records, Medication Lists). Please specify: _____
- ☐ Operative/Procedure Reports
- ☐ Billing Records

PROTECTED UNDER STATE OR FEDERAL LAW

Your health record may include information related to your mental health, alcohol/substance use disorder, sexual assault, sexually transmitted disease, abortion, genetic testing, HIV/AIDS, domestic violence, or other information you may consider sensitive. **We will NOT provide any of the following sensitive information unless you put your initials next to the item below.**

- ☐ Abortion- Consent forms or court orders
- ☐ Domestic violence counseling
- ☐ Alcohol/Substance use disorder
- ☐ Alcohol substance use disorder; must specify exact nature of information needed: _____
- ☐ Details of Mental Health Diagnosis and/or treatment provided by a Psychologist, Psychiatrist, Mental Health Clinical Nurse Practitioner, Licensed Mental Health Counselor, and Licensed Social worker.
- ☐ Other (specify): _____
- ☐ HIV/AIDS test results
- ☐ Sexual assault counseling
- ☐ Sexually transmitted diseases

1. This authorization is voluntary. You need not sign this form in order to ensure treatment, enrollment or eligibility of health benefits. You may inspect or copy the information to be used and/or disclosed. 2. If the organization receiving the information is not a health plan or health care provider, the released information might no longer be protected by Federal privacy laws and might be re-disclosed by the recipient without your authorization. 3. You have a right to revoke this authorization in writing to WPI Health Services at any time unless it has already been acted on. Such revocation will not affect your treatment, enrollment or eligibility of health benefits. 4. This authorization is valid for 90 days from the date of signing unless it has been revoked. 5. Insurance applicants: withholding or release of information may be governed by your insurance company's regulations, state law, and/or Federal law. 6. If you have questions about disclosure and/or use of your medical information, contact at (508) 831-5520.

By signing below, you acknowledge that you have read and understand this form, and that you authorize *WPI Health Services, 100 Institute Road, Worcester MA, 01609-2280, its employees, and/or agents to (select one):*

- ☐ **Request & receive** information **FROM** the health care provider/organization specified below.
- ☐ **Release** information from the medical record of above named patient **TO** the recipient specified below.

Name or check self: ☐ Self		
Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	Email (optional):

Signature of patient/parent/legal representative*: _____

Printed Name: _____ **Date:** _____

Relationship to patient: _____

**If signing as a legal representative, also provide appropriate paperwork to support status*