



# WPI

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 \_\_\_\_/\_\_\_\_/\_\_\_\_

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

### 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.**

- |   |  |
|---|--|
| <input type="checkbox"/> Abortion- Consent forms or court orders  | <input type="checkbox"/> HIV/AIDS test results         |
| <input type="checkbox"/> Domestic violence counseling   | <input type="checkbox"/> Sexual assault counseling     |
| <input type="checkbox"/> Alcohol/Substance use disorder   | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Alcohol substance use disorder; must specify exact nature of information needed: _____   |  |
| <input type="checkbox"/> 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. |  |
| <input type="checkbox"/> Other (specify): _____   |  |

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: <input type="checkbox"/> 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*