Wing Memorial
Hospital and Medical Centers
A Member of UMass Memorial Health Care

Authorization for the Disclosure of Protected Health Information

Please Print

Name: ____ DOB: ___________ SS# or MRN:______________________

I, hereby, authorize **Wing Memorial Hospital & Medical Centers**, a member of UMass Memorial Health Care, Inc.

- ☐ To disclose my protected health information to (listed below) and/ or
- ☐ To obtain my protected health information from:

Name: ____
Address: ____

I understand that my health record may include *general* information related to my mental health, drug/alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. **I understand that this authorization pertains to information obtained on or before the date this authorization was signed.** I authorize the release of the following formation for the period of ________________ through _____________________.

GENERAL RECORDS

☐ Cardiac Studies (Heart)	☐ Home Health Records	☐ Pathology Reports
☐ Consultations	☐ Hospice Records	☐ Patient Discharge Care Form
☐ Discharge Summaries	☐ Immunization Records	☐ Problem List
☐ EEG/EMG/Sleep Studies	☐ Laboratory Reports	☐ Pulmonary Studies
☐ Emergency Service Records	☐ Operative/Procedure Reports	☐ Radiology Reports
☐ Office/Clinic Notes for Dr. ____________________________________		☐ Rehabilitation Notes (Pt, OT, Speech)

STATUTORILY PROTECTED RECORDS

☐ Abortion	☐ Domestic Violence Counseling	☐ Sexual Assault Counseling
☐ Alcohol/Drug Abuse	☐ Genetic Testing/Information	☐ Sexually Transmitted Diseases
☐ Behavioral/Mental Health	☐ HIV/AIDS Results/Treatment	

OTHER (specify) ____

THE PURPOSE OF THE RELEASE OF THIS INFORMATION IS FOR:

☐ Continuing Medical Care	☐ Attorney/Legal Case	☐ Personal Use
☐ Transferring Care	☐ Disability/Insurance Application/Claim	☐ Pre-employment
☐ Other (specify) ____		

This information is needed: ☐ Urgently (within 5 days) ☐ Immediately (today) ☐ Routine (within 30 days)

I UNDERSTAND THAT:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical).
- I may inspect or copy information to be disclosed as provided in the Notice of Information.
- There may be a fee for photocopying my health information.
- Any disclosure carries the potential for unauthorized re-disclosure. I release Wing Memorial Hospital from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke the authorization at any time by presenting a written request to Health Information Management Department (Medical Records) at the address below. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked this authorization will expire on the following date, event or condition: ____. If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply.

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS AND AUTHORIZE THE DISCLOSURE OF THE INFORMATION REQUESTED ABOVE.

______________________________	____________	____________________
Signature of Patient/Parent/Legal Representative	Date	Relationship to Patient

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

______________________________	____________	____________________
Witness to Signature	Date	For Hospital Use Only

PLEASE MAIL YOUR REQUEST TO:

Health Information Management (Medical Records)
Wing Memorial Hospital & Medical Centers
40 Wright Street, Palmer, MA 01069

****A COPY OF THE COMPLETED AUTHORIZATION MUST BE GIVEN TO THE PATIENT****