

BROWN HEALTH MEDICAL GROUP OF MA
Patient Request / Authorization to Use and/or Disclose Protected Health Information

7) EXCLUSION REQUEST:

I request that the following admission(s) / visit(s) be specifically excluded from the request _____ (specify dates of service)

8) PURPOSE OF THE DISCLOSURE:

Medical Care Legal Insurance Personal Other: _____

9) TERM: This Authorization will remain in effect for one year or:

- Until **BHMG MA** fulfills this request.
- From the date of this Authorization until the _____ day of _____ 20_____
- Until the following event occurs: _____
- Other: _____

10) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of **BHMG MA** in writing at the address listed below. The revocation will be effective immediately upon **Brown Health Medical Group of MA @ Hawthorn Medical Associates** receipt of my written notice. I understand that the revocation will not have any effect on any action taken by **BHMG MA** reliance on this Authorization before it received my written notice of revocation.

Attention:
Brown Health Medical Group of MA @ Hawthorn Medical Associates
Medical Records
535 Faunce Corner Road
Dartmouth, MA 02747

11) EFFECT ON TREATMENT/PAYMENT/ENROLLMENT/ELIGIBILITY: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment, payment, health plan enrollment or eligibility for benefits at **BHMG MA**.

12) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal laws once it is disclosed by **BHMG MA**.

13) ACCESS: I understand that in certain circumstances **BHMG MA** has the right to deny me access to all or portions of my Protected Health Information. **BHMG MA** will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize **BHMG MA** to use and/or disclose my health information in the manner described above.

14) _____ Date

Signature of Patient

For Office Use:
 I.D. Verification _____

Printed Name of Patient _____ Witness _____

Authorized patient representative signature, if the patient is a minor or is otherwise unable to sign this Authorization:

15) _____ Date

Signature of Personal Representative

Printed name of Patient Representative _____ 16) _____ Relationship to patient or authority to act for patient

Questions about the release should be directed to the HIM Director.

For Office Use:

- Copy of this authorization provided to the patient
- Copy of this authorization provided to the personal representative

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL APPLICABLE ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

Signature of Personnel completing Request _____ Print Name _____ Date/Time _____