Unit:_____

Acct:_____

Date of Service:_____

WINCHESTER HOSPTIAL
Winchester, Massachusetts

Lab Initials:_____

AUTHORIZATION FOR RELEASE OF INFORMATION

Health Information Management
41 Highland Ave
Winchester, MA 01890
781-756-2170

Health Records
500 Salem Street
Wilmington, MA 01887
978-988-6113

1. I hereby authorize the entity noticed above to release a copy of the following information from the medical record of:

Name:_____Date of Birth:_____

Address:_____

2. Information to be released to:_____

Address:_____

3. Information is being released for the purpose of:
_____Medical _____Personal _____Legal _____ Insurance Other:_____

4. Information requested to be released, include date(s) of service: _____

_____Discharge Summary
_____ER Report
_____Pathology Report
_____Out Patient
_____History & Physical
_____Operative Report
_____Lab,X-ray,EKG,EEG,EMG
_____Entire Medical Record

Other_____
_____

I authorize this release with the understanding that it my include information in one or more of the following categories (please initial the authorized release)

_____a) information relating to treatment for alcohol or drug abuse
_____b) information relating to sexually transmitted diseases
_____c) information relating to communications with social workers, psychotherapists, psychologists, sexual assault, counselors, Domestic violence counselors, allied mental health professionals, human service professionals
_____d) genetic testing
_____e) abortion information and consent forms

I have carefully read this form and fully understand the above statements as they apply to me. I release the hospital from any liability arising from this authorization. I understand this authorization will expire in 90 days unless otherwise specified by me.

I understand I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of treatment provided to me. I may revoke this authorization by requesting such revocation in writing to the entity noted above, and such revocation shall be effective immediately upon receipt unless action has already been taken in reliance upon it.

Please review Winchester Hospital Notice of Privacy Practices for further information.

I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protesting confidentiality.

I am aware that in accordance with the Massachusetts General Law Chapter 111 Section 70 there may be a fee associated with receiving a photocopy of the requested medical records. Please contact the Health Information/Health Records Department at the above phone numbers for further information.

5._____ _____
Signature of Patient or Patient's Authorized Representative — Date

6._____ _____
Printed name of patient or representative — Relationship to patient or authority to act for