Merrimack
Family Medicine
LOWELL GENERAL HOSPITAL

merrimackfamilymedicine.com

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Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ DOB: _____

I hearby authorize **Merrimack Family Medicine** to use and/or disclose the Protected Health Information described below to: _____ for the purpose(s) of:
i.e. Family Member, Provider, etc.

_____
Specific reason for authorization

Protected Health Information allowed to be released:

_____

_____

Dates of care included: _____ to _____

1. I understand that I may inspect or obtain a copy of the protected health information described in this authorization.
2. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of Merrimack Family Medicine (MFM). I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
3. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

COPY PROVIDED: MFM shall provide a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Massachusetts state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release of the following medical information that may be held by MFM: information pertaining to my HIV status, records of mental health care, records of abuse, records of care and treatment for sexually transmitted disease and the records of substance abuse care and treatment.

_____ _____ _____
Date *Signature of Patient* *Relationship to Authorized Recipient*

EXPIRATION DATE: This authorization will expire on (no longer than 1 year) _____.
If not date specified, this authorization will expire 6 months from date of signature.