111 Edgartown Road. Vineyard Haven, MA 02568
Fax: (508) 696-0401 Phone: (508) 693-7900

REQUEST FOR AND RELEASE OF PROTECTED HEALTH INFORMATION FORM

Consumer last name: _____ **First name:** _____ **Middle initial:** _____ **D.O.B.**:_____

Mailing Address: _____

Home phone #:_____ **Work phone #:**_____**Cell phone #:**_____

Martha's Vineyard Community Services (MVCS) Program: ☑ Island Counseling Center ☐ Daybreak Clubhouse ☐ Early Childhood Programs ☐ Family Support Services ☐ Island Employment Services ☐ CONNECT To End Violence ☑ Island Wide Youth Collaborative

☐ RELEASE (SEND) INFORMATION:

I authorize Martha's Vineyard Community Services to release or disclose information pertaining to my identity, prognosis, diagnosis or treatment.
Information to be released, check one: ☐ Verbal/telephone updates ☐ My entire record **or** ☐ Only those portions pertaining to: ☐ Presence in treatment, prognosis, occurrence of relapse ☐ Current medications and psychiatric diagnoses ☐ Medical and social history, educational, family, employment and other assessments; intake sheet; treatment plan, discharge summaries ☐ Other:_____
Disclose to: Name/Facility:_____
Attention: _____
Address:_____
_____
Phone _____Fax_____

Reason for disclosure:

☐ REQUEST (OBTAIN) INFORMATION:

I authorize MVCS to request information from:
Name/Facility: _____
Attention: _____
Address: _____
_____
Phone _____Fax _____
Information requested, check one: ☐ Verbal/telephone updates ☐ My entire record **or** ☐ Only those portions pertaining to: ☐ Presence in the program and brief description of program's services ☐ Ongoing progress in program ☐ Medical history and physical exam ☐ Current medications, lab results and medical diagnoses ☐ Social, educational, family, employment and other assessments; intake sheet; individual or family service or education plan, goal attainment, discharge summaries ☐ Other:_____

Reason for request:

Please send information to:
Medical Records
111 Edgartown Road. Vineyard Haven, MA 02568

Under Massachusetts state law we cannot release certain information unless you give us special permission to release it.
By placing a check in the box I agree to its release: ☐ Abortion ☑ HIV/AIDS information** ☐ Domestic/Sexual abuse ☑ Mental Health ☑ Alcohol or Substance abuse* ☑ Sexually Transmitted Diseases (STD)

***Note:** release of information must comply with the federal HIPAA Privacy Act *and* federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations.** Note: must obtain authorization for *each* requested release of results of HIV/AIDS information. **Note to recipient:** This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that by law, I do not need to consent to the release of/request for this information to receive care or payment for care or to be eligible for enrollment or any benefits. However, I choose to do so willingly and voluntarily for the purpose specified above. My signature acknowledges my receipt and understanding of MVCS's Confidentiality Policy. I understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I understand that I have a right to receive a copy of this form after I have signed it. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the Human Rights Officer or Program Director.

This authorization is valid for Protected Health Information: ☐a one time disclosure of information ☐ongoing confidential information disclosures to the recipient above that automatically expires in 180 days from_____ (same date as date signed), or ☐upon termination from services. I understand that I may revoke this authorization by providing a written statement to the MVCS Program Director. Upon revocation, information will not be released except to the extent that we have already taken action in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I also release Martha's Vineyard Community Services from all legal responsibilities and liabilities that may arise from the release of the information.

Signature of consumer/personal representative _____**Date** _____

If signed by anyone other than the consumer, state the relationship and/or reason and legal authority to do so:
Consumer is: ☐ minor ☐ incompetent ☐ deceased ☐ Parent/legal guardian ☐Legal authority (proof attached)

Signature of witness_____**Date**_____

For use of MVCS: Date request received _____ I.D. provided _____Date released _____
Processed by_____ ☐ Sent by mail ☐ Picked up in person ☐ Sent by Fax
Requested information ☐Received by mail- Date_____ ☐ Received in person-Date_____ ☐ Received by fax-Date _____
Received and filed by _____Date _____