BRIGHAM HEALTH
BRIGHAM AND WOMEN'S
Harbor Medical Associates

Harbor Medical Associates
Medical Records Department
50 Finnell Drive, Unit 1
Weymouth, MA 02188
Phone: 781-803-2266 Ext. 1900
Fax: 781-340-1610

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Last Name_____First Name_____Date of Birth_____
Address_____City_____State_____Zip_____
Home Phone ( ) _____Cell Phone ( ) _____

I hereby authorize Harbor Medical Associates to release protected health information, including copies of the medical record of the above-named patient, to the following person or facility:

Hoosier Services Inc. Phone:800.882.4156; Fax:800.882.4957; Email:service@hoosierservicesinc.com

Name of Person or Facility

18032 Lemon Drive, #C-618	Yorba Linda	CA	92886
Street	**City**	**State**	**Zip**

Purpose of Release: ☐ Medical Care ☐ Legal ☒ Insurance ☐ Personal ☐ Leaving HMA* ☐ Other: _____

**If leaving Harbor Medical Associates please check reason(s):*

☐ Insurance change (*Please Specify New Insurance*) _____

☐ Moved or planning to move ☐ Location-prefer to be closer to home/work ☐ Unable to get an appointment ☐ My provider left HMA

☐ Unable to obtain referral to preferred specialist ☐ Dissatisfied with care/service received (please explain on reverse side)

Information to be released ***Please refer to the Frequently Asked Questions (FAQ) sheet for information regarding fees***

Requests for Radiology Images/Films or CD's and Billing information must be made directly to each of those Departments

☐ Office Visits _____to _____ Specific Provider (s): _____
(Please specify a date range) *(Otherwise, all visits with all HMA providers during the period will be released)*

☐ Lab Results _____to _____ ☐ Radiology Reports _____to _____
(Please specify a date range) *(Please specify a date range)*

☐ Abstract (Includes immunizations, 2 years of office visits and labs, and 5 years of radiology and diagnostic reports) ☐ Immunizations

☐ Complete Medical Record ☐ Other *(Please Specify)* _____

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record and **WILL NOT** be released unless you indicate your specific authorization by **INITIALING** each appropriate category.

____Abortion	____Behavioral/Mental Health	____HIV/AIDS Results/Treatment
____Alcohol/Drug Abuse	____Domestic Violence	____Sexual Assault
____Genetic Testing	____Sexually Transmitted Disease	

I understand that:

- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment or eligibility for benefits will not be affected.
- I may revoke this authorization at any time by submitting a written notice of revocation to HMA at the address listed above. The revocation will be effective upon HMA's receipt of my written notice, except that it will not have any effect on any action already taken by HMA in reliance on this authorization.
- Once HMA has disclosed my health information to the recipient, HMA cannot guarantee that the recipient will not disclose my health information to a third party.
- This authorization will automatically expire in 6 months unless otherwise specified.

_____ _____
Signature of Patient or Authorized Representative Date

For Office Use Only
☐ Check ☐ Visa ☐ MasterCard
Received by_____Date_____

How would you like to receive this information?
☐ Paper Record ☐ CD

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Dear Patient:

We are happy to assist you in obtaining a copy of your medical records. Fulfilling any request for medical records is often a time-consuming, complex and costly process which involves:

- Electronically logging, completing and tracking each request
- Scanning and printing relevant documents
- Reviewing every page to ensure accuracy of information and assurance that only the information you authorized is released.
- Cost to mail the records if applicable

To offset the rising costs associated with processing a medical record request, it has become necessary to ask for payment **before** each request can be processed.

An "abstract" of the medical record is often sufficient to meet the need of the request. Per Massachusetts Statute, Harbor Medical Associates has chosen to charge a cost-based fee of $ 0.76/page but "cap" the fee for a medical record abstract at $25.00. **An abstract includes a Problem List, Medication List, two years Office Notes, two years Lab Reports, five years Radiology, Imaging Reports and five years of Diagnostic Testing.** If you would like a copy of your complete medical record, the fee per page will remain the same; however, the "cap" will be increased to $ 50.00. The fee for medical records may be remitted by check made payable to Harbor Medical Associates. We also accept Visa and MasterCard. Your request will be fulfilled upon receipt of payment.

Please mail all **Medical Record Requests** to:	Harbor Medical Associates Medical Records Department 50 Finnell Drive, Unit 1 Weymouth, MA 02188
Or Fax to: Any questions, please call	Fax (781) 340-1610 Phone (781) 803-2266 Ext. 1900
For **Billing Requests**, please fax to:	Harbor Medical Associates Billing Department Fax (508) 630-2420
Any questions, please call	Phone (781) 952-1500
For **Radiology and Imaging CD's & Films,** please call	Phone (781) 952-1577

Sincerely,

Brigham and Women's Harbor Medical Associates
Medical Records Department

To reference the Fees for Massachusetts, please see Link: http://www.mass.gov/legis/laws/mgl/111-70.htm
CHAPTER 111 Section 70 Records of hospitals or clinics; custody; inspection; copies; fees