Pioneer Valley Plastic Surgery

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INFORMED CONSENT – MEDICAL RECORDS RELEASE
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS / PROTECTED HEALTH INFORMATION

This document must be signed by the patient or person authorized by law.

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Other identifying information, if applicable (other names): _____

Transmission by facsimile or electronic means authorized to expedite transfer of records.

Release to Melissa Johnson, MD's office:
I, _____, hereby authorize _____ to release the records identified on **Exhibit A** to this Authorization for Release of Protected Health Information to Melissa Johnson, MD at Pioneer Valley Plastic Surgery. I agree to be responsible for all photocopying charges associated with the reproduction of such records.

Release from Melissa Johnson, MD's office:
I, _____, hereby authorize Melissa A. Johnson, MD, to release the records identified on **Exhibit A** to this Authorization for Release of Protected Health Information. I agree to be responsible for all photocopying charges associated with the reproduction of such records.

This Authorization for Release of Protected Health Information applies only to the release of the records identified on **Exhibit A**. Such records should be released to (name and address of recipient) for the following purpose(s):

_____
_____
_____
_____

I understand that providing my authorization is voluntary. I need not sign this Authorization for Release of Protected Health Information to continue to receive healthcare treatment from Melissa A. Johnson, MD. I understand that I may revoke this authorization, in writing, at any time except to the extent that disclosure was made prior to the time I revoked this authorization. I further understand that I may inspect and receive copies of the information to be disclosed.

I understand that the health records and information disclosed, or some portion thereof, may be protected by the Federal Health Insurance Portability and Accountability Act (HIPPA). I further understand that it is possible that the information described above may be re-disclosed by the recipient and may no longer be protected by HIPPA. I further understand that my records may be protected under state law and, if so, cannot be disclosed without my written consent unless otherwise provided for in the law and/or regulations.

This Authorization for Release of Protected Health Information shall expire one (1) year from the date below. My signature below acknowledges that I have read, understand, and authorize the release of the information described on **Exhibit A**.

Signature: _____ Date: _____

INFORMED CONSENT – MEDICAL RECORDS RELEASE
EXHIBIT A

DESCRIPTION OF HEALTH INFORMATION SUBJECT TO AUTHORIZATION

By placing a check-mark in the spaces below, I authorize the release of the following records pertaining to services from –

_____ to _____ (insert dates):

____ Complete medical records (all information)

____ All hospital / institution records (including nursing records / progress notes)

____ Transcribed hospital / institution records (includes surgical reports, history/physical exam, consultation reports, discharge summary reports)

____ Laboratory reports

____ Pathology reports

____ Diagnostic imaging reports

____ EKG / cardiac reports

____ Physical / occupational therapy reports

____ Billing statements

____ Physician office / clinical records

____ Implant information (including operative report)

____ Photographs

Release of the following information may be governed by additional laws. I understand and agree that this information will be disclosed only if I place my **initials** in the applicable space next to the type of information.

____ HIV / AIDS information

____ Mental health information

____ Genetic testing information

____ Drug / alcohol diagnosis, treatment, or referral information