tapestry

Acct #: _____
Visit Date: _____
Entered on: _____

Authorization For Use or Disclosure of Medical Record Information

Site Sending/Requesting: _____

Tracking: ☐ **Track** ☐ **Do Not Track**

Patient Information

Name (Print): _____ Date of Birth: _____

Patient Address: _____ Phone#: _____

City: _____ State: _____ Zip: _____ Email:_____

I hereby authorize Tapestry to:

Please choose one: ☐ Release my medical information to ☐ Obtain medical information from

Name/Facility: _____ Attention: _____

Address: _____ Phone#: _____

City: _____ State: _____ Zip: _____ Fax:_____

Purpose of Request: ☐ Personal ☐ Referral ☐ Legal ☐ Insurance ☐ Other

☐ Transfer from Practice/Reason? _____

Specific Records to be Released:

☐ Please provide me with a copy of my entire medical record

☐ Please provide me with the specific information as outlined below:

_____ Date(s) of Treatment _____

_____ Date(s) of Treatment _____

Authorization to Release Protected Health Information

IMPORTANT – It is extremely important that you select either **YES** or **NO** and **INITIAL** each item contained in this section *Authorization to Release Protected Health Information*. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

	Yes	or	**No**	**Initial**
➢ Mental/Behavioral Health Records	☐		☐	_____
➢ HIV/AIDS, including HIV antibody and antigen testing, and HIV/AIDS diagnosis or treatment	☐		☐	_____
➢ Sexually Transmitted Diseases	☐		☐	_____
➢ Abortion	☐		☐	_____

Term: This authorization will remain in effect until Tapestry fulfills this request.
Revocation: I understand that I may revoke this authorization at any time by requesting it of Tapestry in writing at the address below. The revocation will be effective immediately upon Tapestry's receipt of my written notice. I understand that the revocation will not have any effect on any action taken by Tapestry in reliance on this authorization before it received my written notice of revocation.
Written notice is to be mailed to: **Tapestry 1985 Main St., Suite 202, Springfield, MA 01103**.
Effect on Treatment: I understand that I may refuse to sign this authorization for any reason and that such refusal will not affect the commencement, continuation, quality, or payment for such treatment at Tapestry.
Potential for Redisclosure: I understand that the person receiving my Protected Health Information may not be required to comply with Federal and State privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Tapestry.

_____
Signature of Patient Date

_____
Signature of Personal Representative Authority to act for patient Date