CAPE COD HEALTHCARE

MRN (office use only): _____

Instructions:
Please complete, sign and return this form to Medical Records:

1. Fax: 508-790-4548
2. E-mail: cchmedicalrecords@capecodhealth.org
3. Mail to: P.O. Box 640, Hyannis, Ma, 02601
   Attention: CCHC Medical Records Correspondence Office

Check here_____ if you are requesting a copy of your own medical records and would prefer to receive them in electronic format (via secure e-mail).

Authorization for Disclosure of Medical Record Information

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____
Street City/Town State Zip Code

I hereby authorize and request: ☐ Cape Cod Hospital ☐ Falmouth Hospital

To release a copy of my medical records to:_____
Recipient's Name

_____
Recipient's Address Recipient's Phone Number

For the purpose of: ☐ Personal ☐ Insurance ☐ Legal ☐ Other:_____

Requested information: _____

Covering the period from: _____ To:_____

I understand that this Authorization will remain in effect for twelve (12) months or until I provide written notice of revocation to Cape Cod Healthcare, except to the extent that action on it has already begun. I hereby, knowingly and voluntarily authorize Cape Cod Healthcare, Inc. and its affiliates ("CCHC") to use and/or disclose my health information for the purposes noted above. I understand that once such information has been disclosed to the intended recipient, that CCHC cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I am aware that the record to be disclosed pursuant to this Authorization may contain the following subject matter and I am authorizing the release of such highly sensitive information:
- Alcohol/Drug use, abuse and/or treatment
- Treatment for mental illness and/or social services communications
- History of venereal or other communicable disease(s)
- Treatment or testing for HIV/AIDS

I am requesting that the following information be excluded from this release:

_____

Patient or Legal Representative Name (print): _____

Patient or Legal Representative E-Mail Address: _____

Patient or Legal Representative Signature: _____ Date: _____

Relationship to Patient: _____ Phone Number: _____

Witness Signature: _____

For questions please contact the Medical Records Department @ 508-862-5540