HIPAA AUTHORIZATION FORM FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I hereby authorize the use or disclosure of my individually identifiable health information by:

Provider: _____

Address: _____

_____

To be sent to: A Better Chance of Andover
P.O. Box 212
Andover, MA 01810
Attention: Health and Wellness Coordinator
(OR email a scanned document to mail@AndoverABC.org and include it in your summer packet response)

As descried below. I understand that this authorization is voluntary. I understand that information is being released pursuant to this authorization at my request and that the information may be subject to re-disclosure by the recipients and no longer be protected by federal privacy regulations.

Upon presentation of this authorization, or a photocopy thereof, you may copy such records for a representative and you may release such medical or diagnostic materials as the representative requests.

Persons/Organizations receiving the information:

☐ The entire medical record (which may include all records, reports and medical materials, including pathology slides) in your possession, custody or control concerning the patient. "Records" for purposes of this authorization shall include, but not e limited to, correspondence, office notes, doctors' records, laboratory reports, original x-rays, scans, imaging studies or other diagnostic materials, medical reports, tissue blocks and tissue slides.

☐ The following limited health information: The results of any and all COVID-19 tests.

Please initial next to each item below if you specifically authorize the release of health information relating to the testing, diagnosis and treatment for:

____ HIV/AIDS

____ Drug and Alcohol Abuse

____ Mental Health/Psychiatric Disorders

Purpose of use or disclosure of patient's information: For Better Chance of Andover, an organization that provides housing for patient and other students attending Andover Public High School, to make assessments and determinations regarding the patient's living situation in light of the COVID-19 pandemic.

The patient or the patient's representative must read and sign below:

1) Unless earlier revoked, this authorization will expire one year from the date signed below, unless you specify an earlier date here: ___ / ___ / _____ (DD/MM/YEAR).
2) I understand that I may revoke this authorization at any time by notifying the providing organizations in writing, but if I do, it won't have any effect on any actions the provider took before it received the revocation.

_____ _____
Signature of patient or patient's representative Date

If a patient's representative signs this authorization, please complete the following:

_____ _____
Printed name of patient's representative Relationship to patient