Patient Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____

Date of Birth: _____ Medical Record #: _____

Address: _____

_____

Telephone #: _____ Cell #: _____

☐ I hereby authorize _____
to disclose / release my Protected Health Information as requested on this authorization to:

Andrew M Romanowsky, MD LLC
33 Bartlett St Ste 206
Lowell, MA 01852-1317

Tel: 978-458-1293 / Fax: 978-458-6953

1. **Specific information to be disclosed / released:**

- ✓ Progress Notes / Office Visits: Last two (2) progress notes
- ✓ Diagnostic Imaging: All imaging reports on file
  - o Breast Cancer Screening: Mammography
- ✓ Labs: One (1) Year
  - o Cervical Cancer Screening
  - o Colon Cancer Screening - Cologuard, Fecal Globin by Immunochemistry (InSure®)
- ✓ Procedures: All procedures
  - o Colon Cancer Screening – Colonoscopy
- ✓ Specialists: Last progress note(s)
  - o Diabetic Eye Exam (if applicable)
- ✓ Vaccination Record

Purpose of Release: **New Primary Care Physician**

Example: New Primary Care Physician / New Cardiologist / Care Coordination with other Specialist / Personal Use

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Patient's Name: _____ DOB: _____

2. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I do **NOT** permit information of this type, if it exists, to be released. I understand that if I do not check the box, the authorized parties will release such information about me if it exists.

   Do **NOT** release the following information:

   - ☐ HIV/AIDS
   - ☐ Genetic Information
   - ☐ Mental Health
   - ☐ Sexually Transmitted Diseases
   - ☐ Treatment for alcohol and/or drug abuse

3. I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

4. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying the authorized parties. I understand that any previously disclosed information would not be subject to my revocation request.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits, unless otherwise described in the space provided here:

   _____

   _____

This form must be fully complete before signing.

_____ _____

Signature of Patient or Patient's Legal Representative | Date

_____ _____

Print Patient's Name | Date of Birth

_____ _____

Print Name of Legal Representative (if applicable) | Relationship to Patient

☐ *Please accept my facsimile signature as an original*