Please forward all medical records requests and health information to:
Manet Community Health Center
Medical Records Department
110 West Squantum Street
North Quincy, Mass 02171
Secured Fax line: 617-690-6902

Authorization to Release/Obtain Protected Health Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip:_____ Phone (H): _____ (W) or (C):_____

I hereby authorize Manet Community Health Center, Inc. to ☐ *send my health information to: or*
☐*obtain my health information from: (please list below)*

Name:_____
Address:_____
City:_____State:_____
Telephone#_____Fax#_____

Format of information to be released: *(please check appropriate boxes):*

☐ Paper ☐ Fax ☐ Encrypted CD ☐ encrypted e-mail (only small files can be sent)

Please provide a valid e-mail address:_____

☐ I wish to pick up my records: *(medical records department will contact you when they are ready to be picked up and it will be available to be picked up at our central location only)* I authorize the following person to pick up my records for me: _____relationship to patient:_____

Purpose of disclosure:_____

*****Please specify information to be released or obtained: check all that apply:**

☐Partial Records last two years ☐Complete Records ☐ other:_____
☐Lab Results date(s)_____ ☐ Immunization Records ☐ Medication List
☐Problem List ☐ Last Physical (date)_____ ☐ Eye Records ☐ Gyn/Prenatal Records
☐ Imaging Reports date(s)_____

This Authorization also permits to release or obtain information regarding statutorily protected health information *(please check all categories that may be in your health record):*

☐Behavioral/ Mental Health ☐ HIV/Aids Results/Treatment ☐ Domestic Violence
☐ Abortion ☐Genetic Testing ☐Sexually Transmitted Disease ☐Alcohol/Drug Abuse
☐Rape/Sexual Assault ☐ Child/Elder/Disabled Abuse

This authorization will remain in effect for 90 days after the date or as specified:_____ I understand that I may revoke this authorization at any time by providing the medical record department with a written revocation, and that the revocation will be honored except to the extent that this authorization has been acted upon. I also understand that this information may be redisclosed by the recipient if the recipient is not required to follow the privacy regulations or statues. I understand that I am under no obligation to sign this and that the recipients who I am authorizing to use and/ or to use disclose my information to may not condition treatment or payment. I have read and understand the terms of this authorization.

Patient/Parent/Legal Guardian Signature:_____Date:_____

Revised 6/2015