HIPAA Release Form Massachusetts

If you want the	to share information
about you with another person of below (Sections I-VI). This will tell you leave any sections blank, with	r organization, please make sure that you fill out all of the sections us what information you want us to share and who to share it with. If the exception of Section II (B), your permission will not be valid, and information with the person(s) or organization you listed on this form.
Section I	
l.	give my permission for
to share the information about me Section V.	e that I list in Section II with the person(s) or organization that I list in
Section II	
A. Health and personal info	rmation
Please describe the information y to share about you.	ou want the
Please include any dates and deta	ails you want to share.
B. Permission for specific h	nealth information
Only if you choose to share any o	f the following information, please write your initials on the line:
	I specifically give permission, as required by M.G.L. c. 111, § 70F, to
	about HIV antibody and antigen testing and HIV/AIDS diagnosis or
share information in my record ab	I specifically give permission, as required by M.G.L. c. 111, §70G, to out my genetic information.
	I specifically give permission to share information in my record about information is shared, I understand that a specific notice required by
· ·	prohibiting the redisclosure of this confidential information.

Section III – Reason for sharing this information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request" if you are initiating the request.

Section IV – Who may share this information			
I give permission to the person or organization listed below to share the information I listed in Section II:			
Name:			
Organization:			
Address:			
Section V – Who may receive my information			
The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:			
Name:			
Organization:			
Address:			
I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws and that they may be able to further share the information that is given to them.			
Section VI – How long this permission lasts			
This permission to share my information is good until			
If I do not list a date or event, this permission will last for one year from the date it is signed.			
• I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to, and send it or bring it to the place where I am now giving this permission (or fill in a specific location) If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the			

• I understand that I do not have to give permission to share my information with the person(s) or

permission.

organization I listed in Section V.

•	I understand that if I choose not to give this permission or if I cancel my permission, I will still be
	able to receive any treatment or benefits that I am entitled to, as long as this information is not
	needed to determine if I am eligible for services or to pay for the services that I receive.

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Please sign and date this form, and print your name.	
Your signature	_
Date	_
Print your name	-
If this form is being filled out by someone who has the of a minor child, a court-appointed guardian or execuplease:	
Print the name of the person filling out this form:	
Signature of the person filling out this form:	
Describe how this person has legal authority for this in-	dividual: