AUTHORIZATION FOR RELEASE
OF PROTECTED HEALTH INFORMATION/ACCESS REQUEST FORM

Section 1 I authorize Steven E. Locke, M.D., 10 Deer Run, Wayland, MA 01778 to release:

Check all that apply
___ Claims Records
___ Eligibility Records
___ Member Contact Records
___ Referral Records
___ Prior Authorization Records
___ Case Management Records
___ Disease Management Records
_X_ All

_____
(Individual name)
_____
(Date of birth)
_____
(Address)
_____
(Telephone)

These records may be released to:

_____ _____
(Name) (Relationship) (Name) (Relationship)

_____ _____
(Name) (Relationship) (Name) (Relationship)

Information will be used/disclosed for the following purpose(s):

Consultation and/or coordination of care Or Transfer of care

Section 2 **Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV/AIDS Records Release**

If my records contain information about drug and/or alcohol abuse, mental health, sexually transmitted diseases and/or other sensitive information, I agree to its release.

Drugs ☐ Yes ☐ No HIV/AIDS ☐ Yes ☐ No Sexually Transmitted Disease ☐ Yes ☐ No
Alcohol ☐ Yes ☐ No Mental Health ☐ Yes ☐ No

Section 3 **Time Limit / Right to Revoke**

This authorization will expire 90 days from the day of my signature or on the following date or event (please specify):

Until termination of care relationship with Dr. Locke

If I want to cancel this authorization before it expires, I must submit a written notice to the Privacy Officer at Community Health Plan. It is understood that information released prior to my written cancellation was made at my request and with my consent.

Section 4 **Re-disclosure**

I understand that the information disclosed by this authorization could be re-disclosed by the person receiving it and is no longer protected by federal or state legal privacy requirements. Community Health Plan, its affiliates, its employees, and officers are not legally responsible or liable for the re-disclosure of the information indicated on this authorization.

Section 5 **Signature of Individual or Personal Representative Who May Request Disclosure**

I understand that I do not have to sign this authorization, that my treatment or payment for services will not be denied if I do not sign this Authorization, and that I can inspect or copy the Protected Health Information to be used or disclosed.

I hereby authorize Steven Locke, MD to release the Protected Health Information as specified above.

_____ _____
Signature of Individual or Individual's Representative Date

_____ _____
Printed Name of Individual or Individual's Representative Relationship of Individual's Representative

The information disclosed to you may be from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules and state law prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Individual.