Lowell Community Health Center
Health Information
161 Jackson Street, 2nd Floor
Lowell, MA 01852

978-322-8680 (phone) 978-446-9830 (fax) www.lchealth.org

CONSENT TO REQUEST HEALTH RECORDS

Patient Name ______________________________ Date of Birth ______________________________
Address ______________________________ Home Number ______________________________
______________________________ Cell Number ______________________________

1. I hereby authorize and consent to the release of the health records obtained in the course of my treatment at:

   ____

   and furnish same to: **Lowell Community Health Center**
   Health Information Department
   161 Jackson St 2nd Floor
   Lowell, MA 01852

2. Reason for release: Continuity of Care

3. The specific Information to be released is (please check off):

Last HX/PE	☐	Office | Clinic note from the past year	☐
Immunizations/PPD	☐	Hospitalizations/Surgery	☐
Lab results from the past year	☐	Imaging	☐
Health maintenance screens: PAP, ABD US Male > 65, Mammogram, Colonoscopy, DEXA	☐	Other (specify): ______________________	☐

4. If my initials appear here ______________, I specifically authorize release of drug, alcohol abuse, sexually transmitted disease, and/or counseling/psychiatric records. I understand that my drug treatment records are protected by federal regulation "Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Subpart C" and cannot be disclosed without my written consent otherwise provided in the regulations

5. If my initials appear here ______________, I specifically authorize release of my records that contain information about my HIV diagnosis, tests, or treatment of HIV and AIDS, and which may contain reference to my identity as HIV positive or as an AIDS patient.

6. I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclose of the above information about or health records of my condition to authorize personnel of Lowell Community Health Center.

7. I understand this consent is subject to revocation at any time, except to the extent that disclosure made in good faith has already occurred. Revocation must be made in writing. This authorization will expire in one year from the date shown below.

8. Information release may be subject to re-disclosure by recipient.
   Authority of:

______________ ______________________________ ______________________________
Date Signature relationship of representative

______________ ______________________________ ______________________________
Health record number Witness Interpreter