BRIDGEWATER PRIMARY CARE AND CARDIOLOGY, LLC (BPCAC)
Authorization to Use and Disclose Protected Health Information

1) I hereby authorize:_____
(Name of Facility or Person)
to disclose the protected health information of the patient listed below. I understand the information disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, unless prohibited by law. Any third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

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2) Patient Name: _____Date of Birth:_____
Please Print

Address: _____
Street City State Zip

Contact Telephone Number _____ Social Security Number _____

3) Disclose To:

JOHN K. TERZIAN, MD

_____
Person or Facility (please print)

711 WEST CENTER ST WEST BRIDGEWATER, MA 02379

_____
Street (please print) City State Zip

Fax #: 508-583-1120
_____

Phone #: 508-583-1100
_____

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4) Treatment Dates: From: _____ To: _____ or All dates of Service (Circle)

SPECIFIC REPORT(S) REQUESTED:

- ☐ Office/consultation notes
- ☐ Test results
- ☐ Correspondence
- ☐ Immunization history
- ☐ Medication history
- ☐ X-Ray reports
- ☐ Laboratory results
- ☐ Complete record
- ☐ Other Specified _____
- _____
- _____

5) My Highly Confidential Information:

By signing below, I specifically authorize the use and/or disclosure of the following types of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization.

(Note to patient: please draw a line through any item/s listed below if you do not want the information disclosed).

- Mammography Records (except to requesting MD or patient)
- Mental Health Communications
- Psychotherapy Notes
- Social Worker Communication
- Developmental Disability
- HIV/AIDS Testing, Results or Treatment
- Treatment of Substance Abuse (alcohol or drug)
- Child/Elder/Disabled Abuse & Neglect
- Rape/Sexual Abuse
- Sexually Transmitted Disease
- Genetic Testing
- If I am an emancipated minor, information about treatment & diagnosis (except to my parents)

X _____ _____
Signature of Patient or Legal Representative **Date**

6) Purpose of the Disclosure:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other_____

IMPORTANT: PLEASE SIGN AUTHORIZATION FORM ON PAGE 2 →

THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

7) Revocation: I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at this facility; except, however, if my treatment at this facility is for the sole purpose of creating health information for disclosure to the recipient identified in this authorization in which case the facility may refuse to treat me if I do not sign this authorization.

8) Term: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Facility's Privacy Office at the address listed below. The revocation will be effective immediately upon Facility's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Facility in reliance on this Authorization before it received my written notice of revocation.

☐ From the date of this Authorization until the _____day of_____200_____

☐ Until the following event occurs:_____

☐ Other: _____

Access: I understand that I have the right to request access to my Protected Health Information which is maintained by this facility in the facility's Designated Record Set upon completion of the Authorization to Use and Disclose Protected Health Information. I also understand I have the right to request to view and/or have copied my Protected Health Information in its entirety or an abstract. Based on State and Federal Law, the facility has a right to deny me access to all or portions of my Protected Health Information and must notify me in writing. I understand that the facility may charge a reasonable cost based fee associated with copying my Protected Health Information.

If you are requesting Protected Health Information from BPCAC, you may contact:
Bridgewater Primary Care and Cardiology's Privacy Office by mail at:
Bridgewater Primary Care and Cardiology, LLC, Attn: Privacy Officer, 711 West Center Street West Bridgewater, MA 02379 or by Telephone at: (508) 583-1100

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize you to use or disclose my health information in the manner described above.

9) X _____ **10)**_____
Signature of Patient **Date**

_____ ☐ I.D Verification_____
Printed Name of Patient Witness

If the patient is an un-emancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signature:

9) X_____ **10)**_____
Signature of Legal Representative **Date**

_____ **11)**_____
Printed name of Patient Representative Relationship to patient or authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2.