INSTRUCTIONS TO AUTHORIZE USE OR DISCLOSURE OF HEALTH INFORMATION

The Release of Information (ROI) form is used to either:

- Disclose Patient health information from CCA Primary Care to a person or organization; or
- Obtain Patient health information from a person or organization, such as a healthcare provider or hospital, to share with CCA Primary Care.

The ROI form allows health information to be shared via verbal conversation or records access.

Examples of how to use the ROI form

See detailed instructions for completing the ROI Form on page 3.

1. **Patient wants to authorize release of health information to their attorney:**
    - The Patient must complete the ROI form, including the attorney's name and contact information in section 2.
    - No proof of attorney-client relationship is required.
    - This would be the same process for all recipients. The Patient has the right to indicate anyone as a recipient of their health information, including an attorney, patient advocate, family member, etc.
2. **Patient's Personal Representative is an attorney and wants to authorize release of the patients' health information:**
    - As the Patient's Personal Representative, the attorney is authorized to complete the ROI form and release the Patient's health information.
    - The attorney must check the Personal Representative boxes on the ROI form in section 1 and section 3.
    - The attorney is required to provide evidence that they represent the Patient, have the authority to act as the Patient's Personal Representative, and authorize release of the Patient's information.
    - This would be the same process for any type of Personal Representative.

For questions about the ROI form

Call your CCA Primary Care clinic for more information.

Boston Patients: 617-433-9601 (TTY 711)
Springfield Patients: 978-620-0790 (TTY 711)
MetroWest/Worcester: Home Based Patients: 508-250-0770 (TTY 711)

How to initiate other actions on behalf of a CCA Primary Care patient

If you want to…	Use this form	Scope of authority
Designate an Authorized Representative to act on behalf of the Patient to help get healthcare coverage through programs offered by your state Medicaid program. This can also be a person who is authorized by law to act on the Patient's behalf. The selected Authorized Representative must be a person, not an organization.	For Massachusetts patients: MassHealth Authorized Representative Designation (ARD) form For Rhode Island patients: Contact RI Medicaid department for information.	The Authorized Representative may: fill out the state Medicaid application or renewal forms; fill out other Medicaid eligibility or enrollment forms from your state; give proof of information on those forms; get copies of your state's Medicaid eligibility and enrollment notices; and act on the Patient's behalf in all other matters with your state Medicaid program.
Appoint a Health Care Agent to make healthcare decisions on the Patient's behalf	Massachusetts: Health Care Proxy form appoints a health care agent. Rhode Island: Durable Power of Attorney for Healthcare form appoints an attorney in fact.	Depending on the wording of the form, or a court order, the health care agent or attorney in fact has the right to receive all medical information that the Patient would be entitled to receive. After consulting with the Patient's healthcare providers, the health care agent or attorney in fact can make any and all healthcare decisions the Patient would have been able to make, including decisions about life-sustaining treatment. The decisions must be based on the Patient's wishes if known; if not known, then in the Patient's best interests.
Access medical or coverage information when the Patient has died	Letters of Authority from a Probate Court	The Personal Representative of Estate or Executor, in accordance with the Letters of Authority, may have access to any information about the Patient.
Appoint a Power of Attorney to make health care decisions, get access to information, and other actions depending on scope of the Power of Attorney document	Power of Attorney – may also be known as Durable Power of Attorney or Health Care Power of Attorney	The Holder of the Power of Attorney, also known as the "Attorney-in-Fact," can make or do anything that is outlined in the Power of Attorney document. This may or may not include making healthcare decisions.

Instructions to complete the ROI form

Section 1: Patient information

- Print the Patient name, date of birth, address, and phone number.
- Check the box to indicate whether you are the CCA Primary Care patient or their Personal Representative.

Section 2: Authorized Person/Organization Information

- Check the box to indicate if you are requesting to disclose the Patient's health information OR obtain the Patient's health information.
- Print the name, address, phone number, and email address of the Person/Organization for which you are either disclosing or obtaining the health information.
- Indicate the purpose for releasing the information.
- Check the box to indicate how the health information should be delivered. It can be shared verbally or written and/or electronic/paper records can be faxed, emailed, delivered, or picked up.

Section 3: Health Information/Record Details

- Check the box to request a full or partial record. If partial, describe the health information or type of records needed. For example, you want a copy of the last year of lab results, MRI reports, and full vaccination record.
- Indicate the time frame for which the health records should cover. If the Person or Organization is authorized to disclose or obtain information on an ongoing basis (i.e., indefinitely), check the "ongoing" box. This authorizes them to ask for future records (new records or information created since their last request) until this authorization expires.
- You must initial each box below in order for us to release this sensitive information. If you want certain sensitive records released, you must initial the box, otherwise it will not be released.

Section 4: Expiration and Revocation

Indicate the date you want this form to expire or the event upon which it will expire. (For example: upon discharge from the hospital.) Unless otherwise revoked, the authorization is valid while the individual remains a patient of CCA Primary Care.

Section 5: Signature

If you are the Patient, sign and date in the spaces provided. If you are signing this form as Personal Representative of the Patient, print your name in the space, print your name, phone number, and email. Check the box that describes your legal authority to release Patient health information and provide supporting documentation. Examples of acceptable documents include:

- Attorney: Evidence that you are the Patient's attorney
- Guardian/Conservator: Probate court order/decree
- Health Care Agent: Copy of invoked health care proxy and proof of being invoked
- HIPAA Agent/Representative: Attach copy of HIPAA release/authorization
- Representative of Estate/Executor: Copy of appointment letters from probate court
- Power of Attorney (POA): POA that includes authority to use/disclose health information
- Other Advocate: Document that explains your legal authority and relationship

Submit the completed ROI form to:

CCA Primary Care
30 Northampton Street
Boston, MA 02118
Phone: 617-433-9601 (TTY 711)
Fax: 617-445-6538
Hours: 830 am-5 pm, Monday- Friday

RELEASE OF INFORMATION (ROI) FORM

Mail To: CCA Primary Care, 30 Northampton Street, Boston, MA 02118
Phone: 617-433-9601 **Fax**: 617-445-6538

1. Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ____ / ____ / ____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I attest that I am: ☐ The CCA Primary Care Patient ☐ Personal Representative of CCA Primary Care Patient

2. Authorized Person/Organization Information

I authorize CCA Primary Care to ☐ disclose health information to: ☐ obtain health information from:

Person/Organization Name: _____

Address: _____

Phone: _____ Email Address: _____

Purpose: _____

How should the information be released? ☐ Verbally ☐ Fax ☐ Email ☐ Delivery or Pick-Up ☐ Mail

3. Health Information/Record Details

Record: ☐ Full ☐ Partial—If Partial, describe the health records or information needed:

_____

Record Time Frame: _____ / _____ / _____ to _____ / _____ / _____ or ☐ Ongoing

You must **initial** each box for us to release this sensitive information:

☐ Abortion ☐ Reproductive Health ☐ Domestic Violence ☐ HIV

☐ Sexually Transmitted Infection ☐ Behavioral Health ☐ Physical Abuse ☐ AIDS/AIDS-related complex

☐ Alcohol & Substance Use ☐ Genetic Testing

4. Expiration and Revocation

Unless otherwise revoked, this authorization is valid while the individual remains a patient of CCA Primary Care or:

☐ Expiration date: _____ / _____ / _____ ☐ Event: _____

5. Signature

I attest that the signature below is my own and I am legally authorized to sign this document:

Signature: _____ Date: _____

FOR PERSONAL REPRESENTATIVES ONLY:

Print Name: _____ Phone: _____ Email Address: _____

Check box that shows your legal authority to sign on the patient's behalf. Supporting documentation required.

☐ HIPAA Agent/Representative ☐ Health Care Agent/Proxy ☐ Other Advocate ☐ Attorney

☐ Representative of Estate/Executor ☐ Power of Attorney ☐ Guardian/Conservator

I understand that the health information disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by law. I have the right to revoke this Authorization in writing at any time by sending written revocation to the address above. I understand that my treatment, payment, enrollment in the health plan, or eligibility for benefits does not depend on my signing this Authorization. The entity that seeks this Authorization must provide me with a copy of this signed form.