



Harvard Vanguard  
Medical Associates

Atrius Health

Concord Hillside Medical Associates  
86 Baker Ave Ext.  
Concord, MA 01742

**Authorization for Verbal Disclosures  
and/or  
Other Specific Instructions for Health Information**

Patient Name: _____ <small>(Please Print)</small>	Date of Birth: _____
Address: _____	City: _____
State: _____ Zip: _____	Phone: (H) _____ (W) _____

Complete for <b>VERBAL DISCLOSURES</b>	Complete for <b>SPECIFIC INSTRUCTIONS or RESTRICTIONS</b>
<p>I hereby authorize staff of Concord Hillside Medical Associates to speak with the following individual(s) regarding my care and treatment at CHMA.</p> <p>Name: _____ <small>Please Print</small></p> <p>Phone # _____ Relationship: _____</p> <p>Name: _____ <small>Please Print</small></p> <p>Phone # _____ Relationship: _____</p> <p><input type="checkbox"/> Verbal Disclosures restricted to dates of service and/or diagnoses as follows: _____</p> <p><input type="checkbox"/> No restrictions to verbal disclosures</p>	<p><b>Request(s) for other specific instructions and/or restrictions regarding my health information are as noted below:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
VOICE MESSAGES	
<p>I authorize staff of Concord Hillside Medical Associates to leave a message at my home or on my cell phone regarding:</p> <p><input type="checkbox"/> Appointments <input type="checkbox"/> Prescriptions <input type="checkbox"/> Results <input type="checkbox"/> All _____ (patient initials)</p>	<p><b>Note: CHMA will make every reasonable effort to comply with your specific instructions; however, certain circumstances may impede such compliance.</b></p>

- I understand:
- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at CHMA unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
  - I may revoke this authorization at any time by submitting a written notice of revocation to CHMA at the address listed above. The revocation will be effective upon CHMA's receipt of my written notice, except that it will not have any effect on any action already taken by CHMA in reliance on this authorization.
  - Once CHMA has disclosed my health information to the recipient, CHMA cannot guarantee that the recipient will not redisclose my health information to a third party. Such 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.

From the date of signature, this Authorization will be valid for:  3 months  6 months  1 year  \_\_\_\_\_ (other)

*(This authorization will automatically expire 180 days from the date set forth below unless otherwise specified above)*

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions. By my signature below, I hereby, knowingly and voluntarily, authorize Concord Hillside Medical Associates to verbally disclose my health information or fulfill specific instructions in the manner described above.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative Signature: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_