Authorization for Use and Release of Health Information

Thank you for scheduling an appointment with Christine Sacco Clegg, OD at NECO Center for Eye Care Southeastern Massachusetts, 450 Pleasant Street, East Bridgewater MA, 02333. We look forward to your visit.

In order that Dr. Sacco can serve you best, it is important that she be able to review past eye examination reports and history. To help with this process, please see the attached "**Authorization for Use and Release of Health Information**" form. Please fill the form out completely, being sure to obtain the patient's Guardian or Personal Representative signature and date, and send at your earliest convenience (at least three to four weeks prior to the appointment date) to:

Wendy A Vaillencourt
Patient Care Coordinator

450 Pleasant St
E. Bridgewater, MA 02333
NECO Center for Eye Care Southeastern Massachusetts
p: 617-680-8447
f: 857-241-3132
https://www.focusonvisionandvisionloss.org/neco-sema.html

If you should have any questions, please do not hesitate to contact Wendy.

Thank you so much for your time, attention, and help.

Authorization for Use & Release of Health Information

Patient Name _____ Date of_Birth _____ Date _____

Address: _____

Patient Phone Number _____

I authorize the NECO Center for Eye Care SEMA clinic to disclose or request my protected health information to the person or class of persons listed below.

Enter where you would like information sent from, and to whom you would like the information to be sent.

FROM: (e.g. hospital, clinic, or provider name):

Name: _____

Address: _____

PURPOSE: (Check the appropriate box) * Copying fees may apply

- ☐ Medical Care
- ☐ Personal
- ☐ Insurance*
- ☐ School
- ☐ Legal Matters*
- ☐ Other (please specify):

TO: (e.g. To whom you would like the information sent)

Name: NECO Center for Eye Care - SEMA

Address: 450 Pleasant Street
East Bridgewater, MA 02333

Tel #: 617-680-8447

SEND BY:

√ Paper Copy via Mail

☐ Secure E-Mail (**must sign E-Mail consent form on website**), **write e-mail address below**:

_____

√ Fax (provide Fax # here): 857-241-3132

Type of Medical Records Requested:

- √ Notes from most recent eye examination
- ☐ Entire clinical record
- ☐ Most recent contact lens fitting examination/prescription (required for specialty contact lens fittings)
- √ All eye care exam notes within the last 12 months
- ☐ Other: _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below.

- ☐ Alcohol/Drug Abuse Treatment/Referral
- ☐ Sexually-Transmitted Diseases
- ☐ Details of Domestic Violence Victim's Counseling
- ☐ Details of Sexual Assault Victim's Counseling
- ☐ Communication between Patient and Social Worker
- ☐ Details of Mental Health Diagnosis/Treatment provided by Licensed Mental Health Clinician
- ☐ HIV/AIDS Diagnosis and/or Treatment: I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information. Initial here to specifically authorize its release as required by M.G. L. c.111, § 70F.
- ☐ Genetics Testing: I specifically give permission to share information in my record about my genetics testing (excludes therapeutic genetic tests). Initial here to specifically authorize its release as required by M.G. L. c.111, §70G.

Authorization Agreement

- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
- This authorization is voluntary.
- I decline the opportunity to inspect or copy the information released.
- My questions about this authorization form have been answered.
- I understand that I may revoke this authorization at any time by notifying New England College of Optometry Center for Eye Care/New England Eye in writing and that if I choose to do so, my request to revoke will not apply to information that has already been released in response to this authorization.
- I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment or eligibility for care.
- This authorization will expire 12 months from fulfillment of the request unless I specify a different expiration date or expiration event here:

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_____ _____

Signature of Patient or Personal Representative | Relationship if signed by Personal Rep.

_____ _____

Print Name | Date

Return completed form to: NECO Center for Eye Care SEMA, 450 Pleasant Street, East Bridgewater, MA 02333.
Phone: 617-680-8447. Fax: 857-241-3132