The Commonwealth of Massachusetts
County of Plymouth
Sheriff's Department
Plymouth County Correctional Facility

26 Long Pond Road
Plymouth, MA 02360
Telephone: (508) 830-6200
www.pcsdma.org

Date: _____ **Medical Unit Fax: (508) 830-6358**

To: _____

_____

_____

Patient Name: _____ ID #: _____

Date of Birth: _____ SSN (if required): _____

Subject: **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM PCCF**

In order to be properly treated for medical infirmities, I hereby authorize you to forward any and all medical records pertaining to me to:

_____

_____

_____

to familiarize this provider with my medical history, and to assist them in continuing my treatment. I was a patient and/or inmate at your facility on or about: _____ *and was treated for:* _____

I request:

☐ Complete Records	☐ Abstract	☐ Face Sheet
☐ Discharge Summary	☐ History & Physical	☐ Consults
☐ Outpatient Records	☐ X-Rays	☐ Laboratory
☐ Pathology	☐ Physical Therapy	☐ Emergency Report
☐ HIV	☐ Hepatitis	☐ Other, as specified below:

_____

Patient's Signature: _____ Date: _____

Witness: _____ Title: _____

I, _____ also wish to have any confidential records which are kept in my medical record released to the above party (Please initial those that apply)

_____ Psychological or psychiatric impairment

_____ Aquired Immunodeficiency Virus (AIDS)

_____ Test for infection with Human Immunodeficiency Virus (HIV)

_____ Drug and/or alcohol abuse

_____ Sickle Cell Anemia

Patient's Signature: _____ Date: _____

Witness: _____ Title: _____

I hereby release you, as custodian of such records, any school, college, or university, or other educational institution; hospital or other repository of medical records; social service agency, any employer or retail business establishment, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damage of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.

Regarding protected health information, I understand that this authorization is valid until my release from supervision or one year from date above, whichever comes first, at which time this authorization to use or disclose this information expires. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Regarding protected health information, I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the program's privacy contact.

For Health Services Dept. Use

Copied by: _____

Date Sent: _____

Sent to: _____