



AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please complete this form then print and sign on page 2 where indicated. Form can then be faxed to 617-726-3661.

Check here if you are requesting copies of your own medical record and would prefer to receive them in electronic format (via secure e-mail).

PT LAST NAME: _____ PT FIRST NAME: _____ PT DATE OF BIRTH: _____

PATIENT MEDICAL RECORD # _____ EMAIL: _____

PATIENT ADDRESS: STREET: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE CONTACT #: DAY: () _____ EVENING: () _____

I, _____ do hereby authorize Massachusetts General Hospital to release my
 (Patient Name/Legal Representative)
 protected health information including copies of my medical record of care received at Massachusetts General Hospital to the following persons at the locations/facilities listed below, for the purposes described:

Person(s)/Facility/Address (include name and address)	Purpose (check the appropriate box)
1. _____	<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance* <input type="checkbox"/> Legal Matter* <input type="checkbox"/> Personal* <input type="checkbox"/> School <input type="checkbox"/> Other (please specify)* _____ _____
2. _____	

* Please refer to the Partners HealthCare Privacy Notice for information on copying fees that may be associated with this request. ** There may be additional charges for copies of photographs.

INFORMATION TO BE RELEASED (Please check all that apply and specify dates):

Clinic visit notes _____	Photographs** _____
Discharge Summary _____	Radiation reports _____
Lab Reports _____	X-rays/Scan reports _____
Operative Reports _____	Other (please specify) _____
Pathology Reports _____	

Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION


Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

- Yes No **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATES _____
- Yes No **Genetic Screening test results (SPECIFY TYPE OF TEST)** _____
- Yes No **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.
- Yes No **Other(s):** Please List _____
- Yes No Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (*I understand that my permission may not be required to release my mental health records for payment purposes*)
- Yes No Confidential Communications with a Licensed Social Worker
- Yes No Details of Domestic Violence Victims' Counseling
- Yes No Details of Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
 - to the extent that action has been taken in reliance on this authorization
 - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Partners HealthCare
- I understand that this authorization will automatically expire in 6 months unless otherwise specified:

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature:  _____ **Date:** _____
Please print, sign and fax to 617-726-3661

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date _____

Clinic/Office: _____

Pick-up Identification:
_____ license _____ State ID _____ Passport _____ Other Photo ID _____