

**AUTHORIZATION FOR RELEASE OF PROTECTED
OR PRIVILEGED INFORMATION**

- Release Copies of Health/Medical Record
- Review Health/Medical Record
- Obtain Copies of Health/Medical Record From Another Facility

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

PATIENT MEDICAL RECORD # _____ (IF ADDRESSOGRAPH STAMP IS NOT USED)

Patient Address: STREET: _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

Telephone Contact #: Day: () _____ **Evening:** () _____

I, _____ do hereby authorize _____ to release
(Facility)

my protected health information including copies of my medical record of care received at _____
to the following persons at the locations/facilities listed, for the purposes described:

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

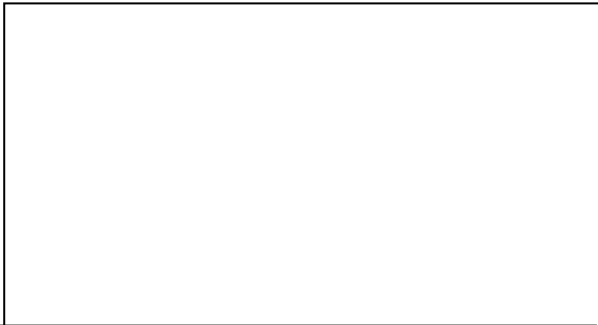
- Please refer to the MGH/Partners HealthCare Privacy Notice for information on copying fees that may be associated with this request

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

- Discharge summary _____
- Lab reports _____
- Operative reports _____
- Outpatient visit notes _____
- Pathology reports _____
- Radiation reports _____
- X-rays/Scan reports _____
- Other (please specify) _____
- Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary):

See Page 2 on Reverse

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION



I request the release of the specific categories of information that I have *INITIALED* below:

_____ (initial)	HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.) SPECIFY DATES _____
_____ (initial)	Genetic test results (excludes therapeutic genetic tests) (SPECIFY TYPE OF TEST) _____
_____ (initial)	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.)
_____ (initial)	Records Pertaining to Sexually Transmitted Diseases
_____ (initial)	Other(s): Please List _____
Confidential Details of:	
_____	Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
_____	Social Work Counseling/Therapy
_____	Domestic Violence Victims' Counseling
_____	Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management, or the Office Manager in my Doctor's Office. 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
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare.
- I understand that this authorization will automatically expire from this date or event: **(PLEASE CHECK ONE):**
 - While under the care of this provider: (Specify): _____
 - 6 months 1 year upon a specific event **(SPECIFY EVENT)** _____

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: _____

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 By: _____

Date: _____

Clinic/Office: _____

