AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Please complete, sign and return this form to*:* *Or* submit via fax to 617-414-4210. Contact us at 617-414-4201 with questions.
Medical Record Department
Boston Medical Center
850 Harrison Avenue/ACC Basement
Boston, MA 02118

Patient Name:
____
Last First MI
Address: ____
Street (include Apt #, if applicable)
____
City State Zip Code
Birth Date ______/______/_________ **Telephone** #: ______________________________ **MR#**____________________________
ALTERNATE ADDRESS: (Please indicate, if you wish your information sent to a different address instead of the one listed above.
____
Street (include Apt #, if applicable)
____
City State Zip Code

I hereby authorize Boston Medical Center to <u>release</u> my protected health information to:
☐ Mail to: ☐ Hold for pick up by:

Name: ____

ADDRESS:____

____

PURPOSE OF DISCLOSURE (Please check one)
☐ Myself ☐ Inspection ☐ Changing physicians ☐ Consultation ☐ School ☐ Legal ☐ Other (specify) _________________

IFORMATION TO BE RELEASED (Please be specific and enter date of service if known):
☐ Entire medical record**______________________**, excluding ________________________________
☐ Medical Record Abstract (e.g. H&P, Operative Rpt, discharge summary Consults, labs, x-rays, pathology)
☐ Clinic notes, specify clinic name___________________________ ☐ Pathology Reports
☐ Consultation Reports_____________________________________ ☐ MRI Reports ____________________
☐ Medication Records_____________________________________ ☐ Itemized Bill **____________________________**
☐ Other (specify content)____

I request the release of the specifically protected or privileged categories of information that I have initialed below:
_**___________________HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
___________________**Alcohol & 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 AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2).
__________________ **Psychiatric Records or Information** _______________ **Sexually Transmitted Diseases (STDS)**
Confidential Details of:
__________Psychotherapy notes (notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or group, joint, family counseling, and that are separate from the medical record.)
_______ Other professional services of a **licensed psychologist** ___________ relate to diagnosis/or treatment of **Hepatitis**
_______ **Domestic Violence** Victim's Counseling Records
_______ **Social Work Counseling/Therapy** _______**Genetic Counseling/records**
_______ **Commonwealth of Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling**

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Director of Medical Records. I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Boston Medical Center will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure. *I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal Confidentiality regulations; however the recipient may be prohibited from disclosing substance abuse information.* I understand that I may inspect or copy the information to be disclosed, for a reasonable charge.

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire **<u>six months</u>** from the date of the signature listed below. 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.
Signature of Patient (18 years or older)____**Date**__________________

Signature of Legal Representative____Relationship to Patient: _________________Date______

Please make a copy of this release for your records.

Revised 02/6/04