



1000956

Authorization for Release of Substance Use Disorder (SUD) Records

(Choose location for the patient)

- Boston Medical Center** **Boston Medical Center – Brighton** **Boston Medical Center – South**
 Brockton Behavioral Health **Other** _____

Mailing Address:

Medical Record Department
850 Harrison Avenue/ACC Basement
Boston, MA 02118

Fax: 617-414-4210
Phone: 617-414-4213

Patient Name: _____
Last First MI

Address: _____
Street (include Apt #, if applicable)

City State Zip Code

Birth Date: ___/___/___ Telephone #: _____ MR#: _____

ALTERNATE ADDRESS: (Please indicate if the information is to be sent to a different address, that is other than the address listed above).

Street (include Apt #, if applicable)

City State Zip Code

I hereby authorize Boston Medical Center Health System to release my protected health information to (choose one method per request):

- Mail to: Hold for pickup by: Fax (only to healthcare facilities): _____ Email: _____

Name: _____

Address: _____

PLEASE CHECK THE FORMAT YOU PREFER TO RECEIVE YOUR MEDICAL RECORDS: PAPER ELECTRONIC

PURPOSE OF DISCLOSURE (Please check one):

- For treatment, payment, and health care operations At my request Other (specify): _____
 Myself Inspection
 Changing physicians Consultation _____
 School Legal

EXPIRATION DATE OR EVENT

- Upon conclusion of treatment Date: _____
 Other expiration event: _____ None, until revoked in writing

INFORMATION TO BE RELEASED (Please be specific and enter dates of service, date range and/or clinic names):

- All SUD-related health information and records _____
 SUD Records for service dates: _____
 Other (specify content) _____

FEDERAL RULES PROHIBIT ANY FURTHER USE OR DISCLOSURE OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 C.F.R. PART 2.



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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 to withdraw authorization, I must write a letter to the Director of Health Information Management and bring it or mail it to the above address.

I understand that the information disclosed because of this consent may be further used or disclosed by the recipient as permitted by the HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, or legislative proceedings against me without a separate court order or specific written consent. I understand that a separate written consent must be completed for uses and disclosure of SUD Information in a civil, criminal, administrative or legislative proceeding against me and may not be combined with other consent.

I understand that once my health information is disclosed, it may no longer be protected by 42 C.F.R. Part 2 and could be re-disclosed by the recipient unless otherwise restricted by law.

I understand that my consent is needed for treatment, payment, and hospital operations. I may refuse to sign this consent, but if I do so, it may limit BMCHS' ability to coordinate my care and payment and may result in the denial of SUD treatment or services. If consent is not provided, BMCHS may require payment before services.

I have received a copy of this signed consent form.

Signature of Patient (18 years or older) _____ **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 _____ **Type of Authority***: _____ **Date** _____

Print Name: _____

* If not parent of minor child, please attach legal document that shows your authority to sign (health care proxy, guardian)

For Office Use Only: I.D. Verification _____