Boston Medical Center
HEALTH SYSTEM

1000957

Consent for Disclosure/Use of Substance Use Disorder (SUD) Records in Legal Proceedings

(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

PERSON(S) OR CLASS OF PERSONS AUTHORIZED TO DISCLOSE THE RECORDS
Name of Program/Provider: _____

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 from (specify date range): _____
☐ Specific documents or categories (describe): _____

PERSON, AGENCY, OR ORGANIZATION TO RECEIVE THE INFORMATION
Name or class(es) of recipients (e.g., “The Office of the District Attorney,” “the Court named below,” or “attorneys representing…”: _____

PURPOSE OF DISCLOSURE (Please check one):
☐ Civil
☐ Criminal
☐ Administrative
☐ Legislative investigation or hearing
Details (e.g., case name, case number, docket number, etc.): _____

EXPIRATION DATE OR EVENT
☐ Upon conclusion of treatment
☐ Date: _____
☐ Other expiration event: _____
☐ None, until revoked in writing

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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 this consent is only for the use or disclosure of SUD records in the legal proceeding specified above and may not be combined with any other consent for another purpose.

I understand that records disclosed may be subject to redisclosure as permitted by law, but cannot be used or disclosed in any criminal, civil, administrative, or legislative proceeding against me unless authorized by this written consent or a specific court order.

I have been informed that signing this consent is voluntary and that refusal to sign does not affect my right to treatment, payment, enrollment, or eligibility for benefits. (Program must specify any consequences of refusal here, if applicable.) ___

_____

_____

I understand that I am entitled to receive 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)