

## AUTHORIZATION to OBTAIN PROTECTED HEALTH INFORMATION (PHI) from a NON-BMC HEALTHCARE PROVIDER

Last First MI  Street (include Apt #, if applicable)  City Stato MR# Zp Code  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  Name of Facility  Street Address  City State Zip Code  Name of Facility  Street Address  to release my protected health Information to Boston Medical Center: (Releasing Facility/Provider, please have Information sent to; Attention:  Department  Boston Medical Center/One Medical Center Place/Boston, MA 02118  PURPOSE OF DISCLOSURE (Please check one)  Consultation To BE RELEASE (Please be specific and enter date of service if known):  First medical record of Consultation Clother (Specify)  Medical Record Abstract (e.g., H&P, Operative Rpt, discharge summary Consults, tabs, x-rays, pathology)  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, discharge summary Consults, tabs, x-rays, pathology)  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, discharge summary Consults, tabs, x-rays, pathology)  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, discharge summary Consults, tabs, x-rays, pathology)  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, discharge summary Consults, tabs, x-rays, pathology)  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, discharge summary Consults, tabs, x-rays, pathology)  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, discharge summary Consults, tabs, x-rays, pathology)  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, Lesser Reports)  Medical Record Reports  Consultation Reports  Medical Record Abstract (e.g., H&P, Operative Rpt, Lesser Reports)  Medical Record Reports  Consultation Reports  Medical Record Record Reports  Consultation Reports  Medical Record Record Reports  Consultation Reports  Alcohel 8 Dray Bahase Record Record Reports  Consultation R	Patient Name:			
Street (include Apt #, if applicable)    State		First	MI	
Birth Date				
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  Name of Facility  Street Address  City State/Zip Code  Name of Facility  Street Address  City State/Zip Code  Name of Facility  State/Zip Code  Name of Facility  Street Address  City State/Zip Code  to release my protected health information to Boston Medical Center: (Releasing Facility/Provider, please have information sent to:)  Attention: Department  Boston Medical Center/One Medical Center Place/Boston, MA 02118  PURPOSE OF DISCLOSURE (Please check one)  Consultation One BERLEASED (Please be specific and enter date of service if known):  Entire medical record, excluding, excluding				
Name of Facility   State   Zip Code	Birth Date/Telephone # ALTERNATE ADDRESS: (Please indicate, if you wis	: MR# sh your information sent to a different address		
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Attention:				
PURPOSE OF DISCLOSURE (Please check one)  Continuity of Care   Consultation   Other (specify)   INFORMATION TO BE RELEASED (Please be specific and enter date of service if known):  Redical Record Abstract (e.g. H&P, Operative Rpt, discharge summary Consults, labs, x-rays, pathology)  Medical Record Abstract (e.g. H&P, Operative Rpt, discharge summary Consults, labs, x-rays, pathology)  Clinic notes, specify clinic name   Dathology Reports   Dathology Reports   Ordination Records   Dathology Reports   Itemized Bill   Dathology Reports   Ordination Records   Dathology Reports   Dathology Report				
PURPOSE OF DISCLOSURE (Please check one)  Continuity of Care   Consultation   Other (specify)   INFORMATION TO BE RELEASED (Please be specific and enter date of service if known):  Entire medical record   excluding   Pathology   Patho	Attention:	Department		
Continuity of Care   Consultation   Other (specify)	Boston Medical Center/One Medical Center Pla	ace/Boston, MA 02118		
Continuity of Care   Consultation   Other (specify)				
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□ Redical 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 □ MRI Reports □ MRI Reports □ Hereived Boston Medical Center to obtain 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 OF THIS INFORMATION UNLESS FURTHER DISCLOSURE OF THIS INFORMATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED DR WRITTED 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 Social Work Counseling/Therapy Genetic Counseling/Therapy □ Omestic Violence Victim's Counseling Records □ Domestic Violence Victim's Counseling Records □ Commonwealth of Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling □ Understand that I cancel this authorization in writing at any time, except to the extent that the above healthcare provider has already sent the information to BMC. 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 authorization	* * * * * * * * * * * * * * * * * * * *	• • • • • • • • • • • • • • • • • • • •		
Medical Record Abstract (e.g. H&P, Operative Rpt, discharge summary Consults, labs, x-rays, pathology)   Clinic notes, specify clinic name				
Consultation Reports			vs. pathology)	
Medication Records				
Medication Records	□ Consultation Reports			
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