



1000175

Authorization for Two-Way Exchange of Information

Patient Name: _____

Date of Birth: _____ MR#: _____

Address: _____

Street

City

State

Zip

I give permission for disclosure of my individually-identified health information and communication between the individuals listed below.

Name: _____

Name: _____

Boston Medical Center, Boston, MA 02118

Address: _____

Telephone: _____

Telephone: _____

Purpose for the authorization:

Referral Coordination of care Other (specify): _____

The information exchange covers the period of my healthcare from:

Specific date(s): _____ to _____ OR All past, present and future encounters/visits

Information to disclose (check all that apply):

Medical Record abstract (ED, History & Physical, Operative Record, Discharge Summary, Consultations, Lab, Pathology/Radiology reports, Procedure Notes, Problem List and Medications)

Treatment plan

Other (specify): _____

If you wish the following information to be shared, you much check each item of information that may be shared.

Behavioral/Mental Health Communications (psychiatrist; psychologist; clinical nurse specialist; educational, marriage, family, rehabilitation, or mental health counselor)

Rape Victim Counseling

Domestic Violence Counseling

Social Worker Communications

Genetic Testing

HIV/AIDS

Sexually Transmitted Diseases

Abortion Consent Form

SUBSTANCE USE DISORDER TREATMENT

All my substance use disorder information, OR

Specific information as checked below:

Name and other identifying information that discloses that I am or was a patient in substance use disorder treatment

Admission date

Assessment results and history

Attendance history

Urine or blood test

Discharge date

Summary of treatment plan, progress and compliance

Other (describe): _____

By signing this authorization form, I understand that:

- I have the right to withdraw my authorization at any time except to the extent that Boston Medical Center has already acted based on this authorization. To take back this authorization, I must do so in writing and present my written revocation to the Director of Medical Records.
- Authorizing the disclosure of my 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.
- Health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal privacy regulations however the recipient may be prohibited from disclosing substance use disorder information.

Date or event on which this authorization will expire: Date: _____ / _____ /20____ OR Event: _____

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire **ONE YEAR** from the date signed below.

Sign Name: _____ Print Name: _____ Date: _____ Time: _____

Patient

Sign Name: _____ Print Name: _____ Date: _____ Time: _____

Parent/Guardian/Surrogate (if applicable)

Sign Name: _____ Print Name: _____ Date: _____ Time: _____

Provider/Physician/Witness (as applicable)

I interpreted the provider's explanation. (Interpreter must sign below, if applicable)

Sign Name: _____ Print Name: _____ Date: _____ Time: _____