Boston Medical Center
HEALTH SYSTEM

999860

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

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 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):

□ Myself □ Inspection □ Changing physicians □ Consultation □ School □ Legal □ Other (specify): _____

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

Please check one or all options: ☐ **Boston Medical Center** ☐ **Boston Medical Center - Brighton** ☐ **Boston Medical Center - South**

Practice Name and/or Provider Name: _____

□ Medical Record Abstract (e.g., ED, H&P, Operative Rpt, Discharge Summary, Consults, Labs, X-rays, Pathology): _____

□ Clinic Notes _____ □ Pathology Reports _____

□ Consultation Reports _____ □ MRI Reports _____

□ Medication Records _____ □ ED Record _____

□ Complete Records _____ □ Other (specify content) _____

TO REQUEST THE RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION, YOU MUST INITIAL BELOW:

_____ HIV Test Results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST).
_____ Sexually Transmitted Disease (STDS)
_____ Commonwealth of Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling
_____ Psychiatric Records or Information
_____ 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).
_____ Genetic Counseling
_____ Domestic Violence
_____ Social Work Counseling/Therapy
_____ Professional services of a licensed psychologist
_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2.

FEDERAL RULES PROHIBIT ANY FURTHER 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 CFR 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 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 **six months** 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 _____

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 _____ **Relationship to Patient**:_____ Date _____

Print Name: _____

Please make a copy of this release for your records.

For Office Use Only: ☐ I.D.Verification _____