

## AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

- \_\_\_ RELEASE COPIES OF HEALTH/MEDICAL RECORD
- \_\_\_ REVIEW HEALTH/MEDICAL RECORD
- \_\_\_ OBTAIN COPIES OF HEALTH/MEDICAL RECORD FROM ANOTHER FACILITY

PATIENT NAME: _____		PATIENT DATE OF BIRTH: _____	
PATIENT MEDICAL RECORD # _____ (IF ADDRESSOGRAPH STAMP IS NOT USED)			
PATIENT ADDRESS: STREET: _____		APT. #: _____	
CITY: _____		STATE: _____	ZIP CODE: _____
TELEPHONE CONTACT #: DAY: ( ) _____		EVENING: ( ) _____	

I, \_\_\_\_\_ do hereby authorize \_\_\_\_\_ to release  
 (Patient Name) (Facility)  
 my protected health information including copies of my medical record of care received at \_\_\_\_\_  
 to the following persons at the locations/facilities listed below, for the purposes described:

Person(s)/Facility/Address (include name and address)	Purpose (check the appropriate box)
1. _____ _____ _____	<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance* <input type="checkbox"/> Legal Matter* <input type="checkbox"/> Personal* <input type="checkbox"/> School <input type="checkbox"/> Other (please specify)* _____
2. _____ _____ _____	<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance* <input type="checkbox"/> Legal Matter* <input type="checkbox"/> Personal* <input type="checkbox"/> School <input type="checkbox"/> Other (please specify)* _____

\* Please refer to the Partners HealthCare Privacy Notice for information on copying fees that may be associated with this request. \*\* There may be additional charges for copies of photographs.

### INFORMATION TO BE RELEASED (Please check all that apply and specify dates):

- |   |   |
|---|---|
| <input type="checkbox"/> Clinic visit notes _____   | <input type="checkbox"/> Photographs** _____          |
| <input type="checkbox"/> Discharge Summary _____  | <input type="checkbox"/> Radiation reports _____      |
| <input type="checkbox"/> Lab Reports _____  | <input type="checkbox"/> X-rays/Scan reports _____    |
| <input type="checkbox"/> Operative Reports _____  | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Pathology Reports _____  |   |
| <input type="checkbox"/> Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary) |   |

**AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION**

**I request the release of the specific categories of information that I have INITIALED below:**

**HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)

**SPECIFY DATES** \_\_\_\_\_

**Genetic Screening test results**  
(SPECIFY TYPE OF TEST) \_\_\_\_\_

**Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2  
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

**Other(s):** Please List \_\_\_\_\_

**Confidential Details of:**

Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)

Social Work Counseling/Therapy

Domestic Violence Victims' Counseling

Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management, or the Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare.
- I understand that this authorization will automatically expire in 6 months unless otherwise specified:

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.

**Patient's Signature:** \_\_\_\_\_ **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:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Relationship of representative to patient:** \_\_\_\_\_

For Internal Use Only

Information Released/Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic/Office: \_\_\_\_\_