

Authorization for Release of Protected or Privileged Health Information

Mail or Fax Release Form To: Release of Information 121 Inner Belt Road, Room 240 Somerville, MA 02143-4453 Fax: 617-726-3661

For questions, contact: 617-726-2361 For copies of radiology images or films, contact (617) 243-6071 / Fax (617) 243-6902

Please print a	III information clearly in order to process your	request in a timely manner.
A. Patient info	ormation	
Patient Name	:	Date of Birth:
Medical Reco	rd #:	
Address:	Street:	Apt. #:
	City:	State: Zip Code:
Preferred Pho	one #:	
B. Permission	n to share: I give my permission to share my բ	protected health information.
Records from	:	
Name of Site Location:		Purpose: (check the appropriate box)
Practice Name:		☐ Medical Care ☐ Insurance*
		☐ Legal*
		☐ Personal
Provider Nam	ne:	□ School
		☐ Other* (please specify)
		*Copying fees may apply
		I Brigham to send your information to): at the above address (section A), otherwise complete the
Name:		Send by:
Address:		☐ Mass General Brigham Patient Gateway (if available)
		☐ Secure Email
		Email Address:
Telephone Number:		☐ Paper Copy via Mail
C. Information	n to be released (please check all that apply,	and MUST specify dates):
□ Date(s) of I	Medical Record Abstract (e.g. History &	☐ Date(s) of Pathology Reports
	perative Report, Consults, Test Reports,	☐ Date(s) of Radiation Reports
	Summary)	☐ Date(s) of Radiology Reports
□ Date(s) of Clinic Visit Notes		
☐ Date(s) of Discharge Summary ☐ Date(s) of Lab Reports		Date(5) of bining records
☐ Date(s) of Operative Reports		The other (piedoe openity below and include dates)



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D. Please ch	eck YES to indicate if you give permission to release the following information if present in your record:	
□ Yes	HIV test results (Patient authorization required for each release request.) Specify dates	
□ Yes	Genetic Screening test results	
	Specify type of test	
□ Yes	Substance Use Disorder Treatment 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 by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.) This consent may be revoked upon oral or written request.	
□ Yes	Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)	
☐ Yes	Confidential Communications with a Licensed Social Worker	
☐ Yes	Details of Domestic Violence/ Intimate Partner Abuse Counseling	
☐ Yes	Details of Sexual Assault Counseling	
E. I understa	and and agree that:	
	eneral Brigham cannot control how the recipient uses or shares the information, and that laws protecting its tiality at Mass General Brigham may or may not protect this information once it has been released to the recipien	
 This aut 	horization is voluntary	
_	ment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form	
	ncel this authorization at any time by submitting a written request to the Department or Office where I y submitted it, except:	
	ass General Brigham has already processed the request (for example, once information is released, Il not be retrieved)	
	igned this authorization as a condition of obtaining insurance. Other laws may provide the insurer a right to contest a claim under the policy or the policy itself	
This authorization will automatically expire 6 months from the date signed unless otherwise specified:		
released	tand that if Mass General Brigham maintains any of my records from outside providers, these will not be I unless I specifically ask for them under "Other" in section C. <u>Please include entity name, provider, and dates if known</u> .	
My ques	tions about this authorization form have been answered	
D . 1' 1/ . 0' .	D.L.	
Patient's Sig	nature: Date:	
	it is a minor, or is not competent to give consent, the signature of a parent, guardian, Il representative is required.	
Signature of	Legal Representative: Date:	
Print Name: Relationship of representative to patient:		
For Internal III	a Only Information Pologood/Povious Pv	
Piokod up by:	e Only: Information Released/Reviewed By:Date:Date:Date:Date:Date:	