BOSTON MEDICAL CENTER

EXCEPTIONAL CARE. WITHOUT EXCEPTION.

ROI

Patient Name:

Patient ID Number:

Physician:

1A

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

Please circle the format you prefer for receiving your medical records:
Paper Electronic

NOTE: Sending your medical records through email is not a secure method and may put your medical records and personal information at risk.

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:

☐ Mail to: ☐ Hold for pick up by:

Name: _____

Address: _____

PURPOSE OF DISCLOSURE (Please check one):

❑ Personal Use ☐ Inspection ☐ Changing physicians ☐ Consultation ☐ School ☐ Legal ☐ Other (specify)_____

INFORMATION TO BE RELEASED (Please be specific and enter dates of service and clinic names if known):

Date of Service for records requested: _____

_____ Abstract (ED, History and Physical Exam, Operative Record, Discharge Summary, Consultations, Laboratory/Pathology/Radiology Reports, Procedure Notes, Problem List and Medications

_____ Individual Report (specify) _____

_____ Hospital Outpatient Clinic (list Clinic) _____

_____ Emergency Department Visit

_____ Immunizations

_____ Medications

_____ Laboratory Tests/Pathology Reports (specify which): _____

_____ Radiology Studies Reports (specify which):_____

_____ Specific Provider Notes (specify which provider): _____

_____ Specific Department (specify which department): _____

_____ Other (specify) _____

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 Diseases (STDS)**

_____ **Commonwealth of Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling**

_____ **Social Work Counseling/Therapy** _____**Genetic Counseling**

_____ **Domestic Violence**

_____ **Alcohol & 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.

_____ **Psychiatric Records or Information.** _____ **Professional services of a licensed psychologist.**

_____ **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).

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** _____

Signature of Legal Representative _____ Relationship to Patient: _____ Date _____

Please make a copy of this release for your records.