Mass General Brigham
Cooley Dickinson Hospital

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 (413) 582-2101 / Fax (413) 582-2923

Authorization for Release of Protected or Privileged Health Information

Please print all information clearly in order to process your request in a timely manner.

A. Patient information

Patient Name: _____ Date of Birth: _____

Medical Record #: _____

Address: Street: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____

B. Permission to share: I give my permission to share my protected health information.

Records from:

Name of Site Location: _____

Practice Name: _____

_____

Provider Name: _____

Purpose: (check the appropriate box)
- ☐ Medical Care
- ☐ Insurance*
- ☐ Legal*
- ☐ Personal
- ☐ School
- ☐ Other* (please specify)

**Copying fees may apply*

Send records to (Enter where you would like Mass General Brigham to send your information to):

☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below:

Name: _____

Address: _____

_____

Telephone Number: _____

Send by:
- ☐ Mass General Brigham Patient Gateway (if available)
- ☐ Secure Email
  Email Address: _____
- ☐ Fax (provide fax number): _____
- ☐ Paper Copy via Mail

C. Information to be released (please check all that apply, and MUST specify dates):

- ☐ Date(s) of Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary) _____
- ☐ Date(s) of Clinic Visit Notes _____
- ☐ Date(s) of Discharge Summary _____
- ☐ Date(s) of Lab Reports _____
- ☐ Date(s) of Operative Reports _____
- ☐ Date(s) of Pathology Reports _____
- ☐ Date(s) of Radiation Reports _____
- ☐ Date(s) of Radiology Reports _____
- ☐ Date(s) of Photographs _____
- ☐ Date(s) of Billing Records _____
- ☐ Other (please specify below and include dates)

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D. Please check 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 understand and agree that:

- Mass General Brigham cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Mass General Brigham may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - if Mass General Brigham has already processed the request (for example, once information is released, it will not be retrieved)
  - if I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with 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:_____
- I understand that if Mass General Brigham maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

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: _____

Picked up by: _____ Pick-up Identification: ☐ License ☐ State ID ☐ Passport ☐ Other Photo ID _____

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