

**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. Enter where you would like Mass General Brigham to send your information to:

<p><b>RECORDS FROM:</b>  <b>Name of Site Location:</b> _____          Practice Name: _____          Provider Name: _____</p>	<p><b>PURPOSE:</b> (check the appropriate box)</p> <p><input type="checkbox"/> Medical Care  <input type="checkbox"/> Insurance  <input type="checkbox"/> Legal  <input type="checkbox"/> Personal  <input type="checkbox"/> School          Other (please specify) _____  <i>Copying fees may apply</i></p>
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**SEND RECORDS TO: (e.g. to whom you would like the information sent):**

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):

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Date(s) of Medical Record Abstract (e.g. History &amp; Physical, Operative Report, Consults, Test Reports, Discharge Summary) _____</li> <li><input type="checkbox"/> Date(s) of Clinic Visit Notes _____</li> <li><input type="checkbox"/> Date(s) of Discharge Summary _____</li> <li><input type="checkbox"/> Date(s) of Lab Reports _____</li> <li><input type="checkbox"/> Date(s) of Operative Reports _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Date(s) of Pathology Reports _____</li> <li><input type="checkbox"/> Date(s) of Radiation Reports _____</li> <li><input type="checkbox"/> Date(s) of Radiology Reports _____</li> <li><input type="checkbox"/> Date(s) of Photographs _____</li> <li><input type="checkbox"/> Date(s) of Billing Records _____</li> <li><input type="checkbox"/> Other (please specify below and include dates)<br/>_____</li> </ul> |
|---|--|

**AUTHORIZATION FOR RELEASE OF PROTECTED  
OR PRIVILEGED HEALTH INFORMATION****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 \_\_\_\_\_