

**COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF CORRECTION
HEALTH SERVICES DIVISION**

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

PATIENT'S NAME: _____ **SS#** _____

ID# _____ **DATE OF BIRTH** _____

INSTITUTION: _____

_____ To provide me with a complete copy/abstract of my medical record for my personal use. I agree to accept responsibility for payment of any fees charged for this service. Provide dates of service.

DATE OF TREATMENT _____
INFORMATION REQUESTED _____

_____ To allow _____ who is _____
(Name of authorized person) (relationship, e.g., physician, attorney)
to be furnished a complete copy/abstract of my medical record.
Provide dates of service _____
(Specify scope of procedures or N/A)

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me and do herein expressly and voluntarily consent to disclosure for the purpose or need and to the extent or nature as stated. I further understand that I may revoke this consent at any time. Except where disclosure has already been made or upon occurrence of the event: the purpose for which this disclosure is hereby authorized. Deletions may be made as required by the privacy laws of Massachusetts.

This Authorization for Release of information (unless expressly revoked earlier) expires sixty (60) days from the date last signed by the patient or authorized agent.

Patient's signature _____ **Date** _____

Witness signature _____ **Date** _____

Copied _____ **pages @** _____ **Total Paid \$** _____
pages _____ **Price per page** _____ **Date** _____

Additional Signature & Relationship to inmate, if required

_____ **Date** _____

Witness

If inmate is deceased, please provide proof of executor or administratrix.

**COMMONWEALTH OF MASSACHUSETTS
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AUTHORIZATION TO RELEASE SENSITIVE MEDICAL INFORMATION

NAME & ADDRESS OF INMATE

DATE _____

ID # _____

SS # _____

Date of Birth _____ **Institution** _____

NAME & ADDRESS OF PERSON REQUESTING MEDICAL RECORD (OTHER THAN INMATE)

Purpose of disclosure: _____

Information to be released: _____

I hereby authorize the release of the information stated above, including any information regarding mental health conditions, drugs or alcohol abuse, HIV test results and/or any AIDS related information. Any other use or disclosure of this information is forbidden. This consent will expire on _____ or sixty days after today's date. This consent is subject to revocation at any time except to the extent that action has been taken in reliance there on.

Signature of inmate

Date

Witness

Date

Additional Signature & Relationship to inmate, if required. Date

If inmate is deceased, please provide proof of executor or administratrix.



Authorization to Release Information Massachusetts Department of Correction Health Services			Status: ☐ Adult ☐ Juvenile	
Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date:

I Authorize / Autorizo:	To Release Information To / A divulgar Información a:
Name of organization or individual / Nombre Wellpath	Name of organization or individual / Nombre
Address / Dirección	Address / Dirección

- 1 This authorization includes records relating to the following (please check) / La presente autorización comprende los registros relacionados con lo que se detalla a continuación (por favor, marque la opción correcta):
- ☐ All remaining records / Otros registros restantes ☐ Specify / Especificar _____
- ☐ Mental health treatment / Tratamiento de salud mental
- ☐ Chemical dependency treatment / Tratamiento de drogadicción o alcoholismo
- ☐ HIV or AIDS related tests and treatment / Tratamiento o pruebas de SIDA o VIH
- 2 Purpose for disclosure (this line must be completed) / Propósito de la divulgación (se debe completar este renglón): _____
3. Indicate dates of interest / Indique las fechas importantes. _____
If no date-range is provided, release will cover the previous year only / Si no se indica el periodo de divulgación, la misma tendrá lugar sólo por el término del año anterior.
4. I understand that I may revoke this authorization at any time by providing written notice, except to the extent that release of information has already occurred in reliance upon it.
4. Comprendo que puedo revocar la presente autorización en cualquier momento siempre que notifique mi decisión por escrito, salvo que la divulgación de mi información se haya efectuado dependiendo de dicha autorización.
5. I understand that under Federal Law (42CFR Part 2) records relating to treatment for chemical dependency cannot be released without my specific authorization as indicated under "1."
5. Comprendo que conforme a la Ley Federal (42CFR – Código de Normativa Federal – Parte 2) los registros relacionados con el tratamiento para el alcoholismo o drogadicción no pueden divulgarse sin mi previa autorización específica tal como indica el punto "1."
6. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
6. Entiendo que la información utilizada o revelada conforme a esta autorización puede ser divulgada por el destinatario y ya no estar protegida bajo ley federal o estatal
7. I understand that I will receive treatment even if I refuse to provide approval, but also understand that refusing to authorize information may affect the nature of the treatment provided.
7. Comprendo que recibiré tratamiento incluso si me niego a otorgar mi aprobación; pero, asimismo comprendo que rehusarme a autorizar la divulgación de mi información puede afectar la naturaleza del tratamiento que se me proporcione.
8. I agree to hold harmless all persons acting upon this authorization in good faith.
8. Acepto eximir de responsabilidad a todas las personas que actúen con buena fe bajo la presente autorización.
9. It is my intention that a photocopy will be as valid as this original.
9. Manifiesto que una fotocopia tendrá el mismo valor que su copia original.
10. This authorization shall be valid for one year from the date of my signature.
10. La presente autorización tendrá validez por el plazo de un año a partir de la fecha de mi firma.

Patient or authorized signature / Firma del paciente o persona autorizada	Date / Fecha
If other than patient signature, relationship to patient / Si no es la firma del paciente, indicar relación con el paciente	Date / Fecha
Witness signature / Firma del testigo	Date / Fecha





LEMUEL SHATTUCK HOSPITAL
170 Morton Street Jamaica Plain, MA 02130 (617) 522-8110

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, with Date of Birth _____, authorize the Lemuel Shattuck Hospital to release the following information (Please check all that apply):

- [] Abstract (Discharge Summary, History & Physical, Laboratory Results, Special Tests, Operative Report)
[] Discharge Summary [] Inpatient Record
[] X Ray, Special Studies [] Laboratory Results
[] Outpatient Clinic Visits [] Psychiatric Treatment(s)
[] Rape victim counseling and treatment of sexually transmitted diseases
[] Specific Treatment (describe and give dates) _____
[] Complete record

Permission about Specific Health Information (Please put your initials if you are choosing to share any of the following information.):

_____ I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

_____ I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

_____ I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

Send To: Agency, Facility, Person: _____

Name: _____ Address: _____

City/State/Zip: _____ Telephone (if known): _____

The purpose of this information is:

- [] medical care or mental health care [] to obtain insurance and/or government benefits
[] other, if so describe: _____

This consent is valid for sixty (60) days from the date I sign this authorization, and may be revoked at any time by providing a written notice to the Director of Health Information Management, unless action on it has already begun.

I understand that if the person or entity that receives the information is *not* a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

This information has been disclosed to you from records protected under Federal Law 42 CFR Part 2 and cannot be disclosed without my written consent. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I release the Lemuel Shattuck Hospital, its employees, and attending physicians from legal responsibility or liability to the extent indicated and authorized herein.

Signed: (Patient's full name) _____ Date: _____

Authorized Representative : _____ Relationship to Patient: _____

Witness: _____ Date: _____