

**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
DEPARTMENT OF CORRECTION
HEALTH SERVICES DIVISION

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.

MASSACHUSETTS DEPARTMENT OF CORRECTION - HEALTH SERVICES DIVISION
RELEASE (Inmate)
(OUTSIDE MEDICAL SERVICES)

I, _____, wish to obtain the medical services listed below. I agree to assume full responsibility for payment for said services. In so doing, I understand that neither the Commonwealth of Massachusetts Department of Correction, nor any of its agents, officials, employees, nor the medical provider for the Department of Correction, will incur any financial obligations for said services. Further, I, for myself and my agents, heirs, employees, successors, and assigns, agree to release and forever discharge the Department Of Correction and all its agents, officials, employees, and the medical provider for the Department of Correction, from any and all liability, causes of action, claims, suits, damages, obligations, agreements, debts, judgments, or any other matter arising out of or in any way connected directly or indirectly, with said medical services except as otherwise provided by state law.

Name and Address of Provider

Nature of Services:

Signed, _____
(Inmate's Signature)

Date: _____

Witness: _____

Title: _____

Date: _____