Boston Medical Center
HEALTH SYSTEM

999860

Authorization for Release of Protected Health Information (PHI)

(Choose location for the patient)

☐ **Boston Medical Center** ☐ **Boston Medical Center – Brighton** ☐ **Boston Medical Center – South**
☐ **Brockton Behavioral Health** ☐ **Other** _____

Mailing Address:
Medical Record Department
850 Harrison Avenue/ACC Basement
Boston, MA 02118

Fax: 617-414-4210
Phone: 617-414-4213

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 Health System to release my protected health information to (choose one method per request)***:***

☐ Mail to: ☐ Hold for pickup by: ☐ Fax (only to healthcare facilities): _____ ☐ Email: _____

Name: _____

Address: _____

PLEASE CHECK THE FORMAT YOU PREFER TO RECEIVE YOUR MEDICAL RECORDS: ☐ PAPER ☐ ELECTRONIC

PURPOSE OF DISCLOSURE (Please check one):
☐ Myself ☐ Inspection ☐ Changing physicians ☐ Consultation ☐ School ☐ Legal ☐ Other (specify) _____

INFORMATION TO BE RELEASED (Please be specific and enter dates of service, date range and/or clinic names):

☐ Medical Record Abstract (e.g., ED, H&P, Operative Rpt, Discharge Summary, Consults, Labs, X-rays, Pathology): _____
☐ Clinic Notes: _____ ☐ Pathology Reports _____
☐ Consultation Reports: _____ ☐ MRI Reports _____
☐ Medication Records: _____ ☐ ED Record _____
☐ Complete Records: _____ ☐ Other (specify content) _____
☐ Verbal: _____

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 Disease (STDS)
_____ Commonwealth of Massachusetts Sexual Assault
_____ Domestic Violence Counseling
_____ Details of Mental Health treatment by a Psychiatrist; Psychologist; Clinical Nurse Specialist; Licensed Social Worker; or Licensed Mental Health Counselor
_____ Genetic Testing Results
_____ Evidence Collection Kit/Sexual Assault Counseling
_____ Rape Victim Counseling

To obtain Substance Use Disorder records, please fill out the AUTHORIZATION FOR RELEASE OF SUBSTANCE USE DISORDER (SUD) RECORDS.

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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 to withdraw authorization, I must write a letter to the Director of Health Information Management and bring it or mail it to the above address. 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 under this authorization may be subject to redisclosure by the recipient and no longer protected by Federal Confidentiality regulations.* I understand that I may inspect or copy the information to be disclosed, for a reasonable charge.

Date or event on which this expiration will expire: ___/____/20___ OR Event _____

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_____

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 _____ **Type of Authority***: _____ Date_____

Print Name:_____

* If not parent of minor child, please attach legal document that shows your authority to sign (health care proxy, guardian)

For Office Use Only: ☐ I.D. Verification _____