BRIGHAM AND WOMEN'S HOSPITAL
A Teaching Affiliate of Harvard Medical School
75 Francis Street, Boston, Massachusetts 02115

PATIENT IDENTIFICATION AREA

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

PATIENT NAME: ______________________________ PATIENT DATE OF BIRTH: ______________

PATIENT MEDICAL RECORD # ____________________ (IF ADDRESSOGRAPH STAMP IS NOT USED)

PATIENT ADDRESS: STREET: ______________________________ APT. #: __________

CITY: ______________________ STATE: ______ ZIP CODE: ________

TELEPHONE CONTACT #: DAY: ( ) ______________ EVENING: ( ) ________________

☐ I, ______________________ , do hereby authorize release of my protected health information including
Patient Name)
copies of my medical record of care received at

______________________________ to

BWH Cardiac Rehabilitation
20 Patriot Place
Foxborough MA 02035

OR

☐ I, ______________________ , do hereby authorize ______________________ to release
(Patient Name) *(Name of Physician)*
my protected health information including copies of my medical record of care received by:

____
(Name of Physician)

____
(Street Address)

____
(City, State Zip code)

____
FAX:

INFORMATION TO BE RELEASED ***(Please check all that apply and specify dates):***

- ☐ Clinic visit notes ______________________
- ☐ Discharge Summary ______________________
- ☐ Lab Reports ______________________
- ☐ Operative Reports ______________________
- ☐ Pathology Reports ______________________
- ☐ Photographs ______________________
- ☐ Radiation reports ______________________
- ☐ X-rays/Scan reports ______________________
- ☐ Other *(please specify)* ______________________
- ☐ Medical Record Abstract *(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)*

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Please answer YES or NO to each of the following questions, to indicate if we may release the information below (if it is in your medical record):

☐ Yes ☐ No **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATES ______________________________

☐ Yes ☐ No **Genetic Screening test results (SPECIFY TYPE OF TEST)** ______________________

☐ Yes ☐ No **Alcohol and Drug Abuse 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 OR 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 ☐ No **Other(s):** Please List ____

☐ Yes ☐ No 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 ☐ No Confidential Communications with a Licensed Social Worker

☐ Yes ☐ No Details of Domestic Violence Victims' Counseling

☐ Yes ☐ No Details of Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Department or Office where I originally submitted this authorization. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Partners HealthCare
- I understand that this authorization will automatically expire in 6 months unless otherwise specified:

____

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.

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 ________________

Clinic/Office: ____

Pick-up Identification:

__________ license __________ State ID __________ Passport __________ Other Photo ID ____________________