Brigham and Women's Hospital
Founding Member, Mass General Brigham

REQUEST FOR INFORMATION FROM AN OUTSIDE HEALTH CARE ORGANIZATION

Please print all information clearly in order to submit your request in a timely manner

A. PATIENT INFORMATION

PATIENT NAME: ______________________ **DATE OF BIRTH:** ______________

ADDRESS: **STREET:** ______________________ **APT #:** __________

CITY: ____________ **STATE:** ________ **ZIP CODE:** ______

PREFERRED PHONE #: (   ) __________

B. PERMISSION TO SHARE: I give my permission to share my protected health information.

RECORDS FROM: (e.g. hospital, clinic, or provider)

Name of Site Location: ______________________

Address: ______________________

____

Telephone Number: ______________________

Fax Number: ______________________

PURPOSE: (check the appropriate box)

☐ Medical Care
☐ Insurance
☐ Legal
☐ Personal
☐ School

Other (please specify) ______________________

____

SEND RECORDS TO: (specify clinic or department at Mass General Brigham)

Name: BWH Cardiac Rehabilitation

Address: 20 Patriots Place, Foxborough, MA 02035

____

Telephone Number: 508-718-4661

SEND BY:

☐ Fax (provide fax number): 508-718-4200
☐ Paper Copy via Mail
☐ Secure Email ______________________

We do not accept records on CDs or external (flash) drive.

C. INFORMATION TO BE RELEASED (Please check all that apply and MUST specify date(s))

☐ Date(s) of Medical Record Abstracts ______________
(e.g., History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
☐ Date(s) of Clinic Visit Notes ______________
☐ Date(s) of Lab Reports ______________
☐ Date(s) of Operative Reports ______________
☐ Date(s) of Pathology Reports ______________
☐ Date(s) of Radiation Reports ______________
☐ Date(s) of Radiology Reports ______________
☐ Date(s) of Photographs ______________
☐ Other (please specify below and include dates)

____

____

 This document is not part of the medical record MGB00085 (09/21)

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D. SPECIAL PERMISSION

Please check YES to indicate if you give permission for us to receive 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 Abuse 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:

- 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 received the information
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
  ____
- 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**: ______________