PARTNERS®
HEALTHCARE

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

___ RELEASE COPIES OF HEALTH/MEDICAL RECORD
___ REVIEW HEALTH/MEDICAL RECORD
___ OBTAIN COPIES OF HEALTH/MEDICAL RECORD FROM ANOTHER FACILITY

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 _____ to release
(Patient Name/Legal Representative) (Facility)
my protected health information including copies of my medical record of care received at _____
to the following persons at the locations/facilities listed below, for the purposes described:

Person(s)/Facility/Address (include name and address)		Purpose *(check the appropriate box)*
1.	2.	☐ Medical Care
		☐ Insurance*
		☐ Legal Matter*
		☐ Personal*
		☐ School
		☐ Other (please specify)*

* ***Please refer to the Partners HealthCare Privacy Notice for information on copying fees that may be associated with this request. ** There may be additional charges for copies of photographs.***

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)*

_____
_____
_____

See Page 2 on Reverse

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

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 redisclosed 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 _____