



AUTHORIZATION FOR RELEASE OF PROTECTED
OR PRIVILEGED INFORMATION

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

PATIENT MEDICAL RECORD #: _____

PATIENT ADDRESS: _____

TELEPHONE #: DAY () _____ EVENING () _____

I, _____ do hereby authorize Massachusetts
General Hospital to release health information including copies of my medical record of care received at

_____ to the following person(s) or classes of persons (e.g., doctors, lawyers) at the locations/facilities listed, for the purposes described:

PERSON/CLASS OF PERSON/FACILITY/ADDRESS (include name and address)		Purpose (check the appropriate box)*
1. _____	2. _____	<input type="checkbox"/> Medical Care
_____	_____	<input type="checkbox"/> Legal Matter
_____	_____	<input type="checkbox"/> Insurance
_____	_____	<input type="checkbox"/> Personal
		<input type="checkbox"/> Other (please specify) _____

* Please refer to the MGH/Partners HealthCare Privacy Notice for information on copying fees that may be associated with copying your records for some of these purposes.

INFORMATION TO BE RELEASED

(Please check all that apply and specify dates):

- Clinic visit notes _____
- Operative reports _____
- Discharge summary _____
- X-rays/Scan reports _____
- Pathology reports _____
- Radiology reports _____
- Lab reports _____
- Other (please specify) _____
- Medical Record Abstract (e.g., History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
(specify elements to be released) _____

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AUTHORIZATION FOR RELEASE OF SPECIFICALLY
PROTECTED OR PRIVILEGED INFORMATION

I request the release of the specific categories of information that I have INITIALED below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST)
SPECIFY DATES _____

_____ Genetic test results (excludes therapeutic genetic tests)
SPECIFY TYPE OF TEST _____

_____ 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.)

_____ Records pertaining to sexually transmitted diseases

_____ Other(s): Please list _____

Confidential Details of:

_____ Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)

_____ Social Work Counseling/Therapy

_____ Domestic Violence Victims' Counseling

_____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Services, or the Office Manager in my Doctor's Office. 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 disclosed by the recipient is no longer protected by Partners HealthCare.
- I understand that this authorization will automatically expire from this date or event: (PLEASE CHECK ONE):
 - While under the care of this provider: **(SPECIFY):** _____
 - 6 months 1 year upon a specific event: **(SPECIFY):** _____

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:** _____