AUTHORIZATION to OBTAIN PROTECTED HEALTH INFORMATION (PHI) from a NON-BMC HEALTHCARE PROVIDER

Patient Name:

_____
Last First MI

Address: _____
Street (include Apt #, if applicable)

_____
City State Zip Code

Birth Date _____/_____/_____ **Telephone** #: _____ **MR#**_____

ALTERNATE ADDRESS: (Please indicate, if you wish your information sent to a different address instead of the one listed above.

_____
Street (include Apt #, if applicable)

_____
City State Zip Code

I hereby authorize

_____
Name of Facility

_____
Street Address **City** **State/Zip Code**

to release my protected health information to Boston Medical Center: (Releasing Facility/Provider, please have information sent to:)

Attention: _____ Department_____

Boston Medical Center/One Medical Center Place/Boston, MA 02118

PURPOSE OF DISCLOSURE (Please check one)

❑ Continuity of Care ☐ Consultation ☐ Other (specify) _____

INFORMATION TO BE RELEASED (Please be specific and enter date of service if known):

❑ Entire medical record_____, excluding _____

❑ Medical Record Abstract (e.g. H&P, Operative Rpt, discharge summary Consults, labs, x-rays, pathology)

❑ Clinic notes, specify clinic name_____ ☐ **Pathology** Reports

❑ Consultation Reports_____ ☐ MRI Reports _____

❑ Medication Records_____ ☐ Itemized Bill _____

❑ ☐ Other (specify content)_____

I hereby authorized Boston Medical Center to obtain specifically protected or privileged categories of information that I have initialed below:

_____**HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)

_____**Alcohol & 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 AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2).

_____ **Psychiatric Records or Information** _____ **Sexually Transmitted Diseases (STDS)**

Confidential Details of:

_____**Psychotherapy notes** (notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or group, joint, family counseling, and that are separate from the medical record.)

_____ Other professional services of a **licensed psychologist** _____ relate to diagnosis/or treatment of **Hepatitis**

_____ **Social Work Counseling/Therapy** _____**Genetic Counseling/records**

_____ **Domestic Violence** Victim's Counseling Records

_____ **Commonwealth of Massachusetts Sexual Assault Evidence Collection Kit/Sexual Assault Counseling**

I understand that I cancel this authorization in writing at any time, except to the extent that the above healthcare provider has already sent the information to BMC. 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 pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by Federal Confidentiality regulations; however the recipient may be prohibited from disclosing substance abuse information.*

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_____**Date**_____

(Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal representative is required for patients under the age 18 without emancipated status or a special condition.)

Signature of Legal Representative_____Relationship to Patient_____Date_____

Please make a copy of this release for your records.

Revised 02/6/04