Authorization for Verbal Communication of Protected Health Information

INSTRUCTIONS:

Section 1

- Print the name, address, date of birth, medical record number (if known), and email address (optional) of the patient whose Protected Health Information (PHI) is being reviewed.

Section 2

- Provide the name, address and phone number of DFCI clinical staff, who you give permission to access and discuss content of your medical record.

Section 3

- Indicate any limitations on what can be discussed within your record.
- Indicate the Purpose for which records are being reviewed by checking the appropriate box.
  - If no box relates to the intended purpose, check "Other" and state the purpose for the release (Example: Genetics)
- Indicate the number of discussions allowed pertaining to the content within your medical record.

Section 4

- Privileged/Sensitive Information – Information listed in Section 4 requires additional authorization. To have this information discussed, initial as appropriate.
  - For more information on Dana-Farber's privacy policies, please visit www.dana-farber.org/privacy

Section 5

- The patient whose PHI is being reviewed must sign and date the authorization, OR the Authorized Representative of the patient must sign and date the authorization.
  - A physical signature is required in order for the form to be valid.
  - If the Authorized Representative of the patient is a Guardian, Executor/Executrix of the Estate, or Power of Attorney, legal documentation proving authority to act on behalf of the patient must be provided.
  - A Health Care Proxy Form is not accepted as legal documentation when providing permission to a third party to review your medical record.

Return this form to Health Information Services using the following contact information:

Mail: DFCI HIS – Correspondence
27 Drydock Ave, 4th Floor
Boston, MA 02210

Fax: 617-632-2020
Email: DFCIHIS_ScanningDocuments@dfci.harvard.edu

Dana-Farber Cancer Institute

REQUEST & AUTHORIZATION FOR VERBAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

SECTION 1

MEDICAL RECORD #_____ **DATE OF BIRTH**_____

Patient Name: _____
(Last) (First) (M.I.)

Patient Address: _____

_____

Patient Telephone (for contact): ( ) _____work/home/cell (circle one)

SECTION 2

I,_____, request and do authorize members of my care team to discuss my or my child's protected health information, including information relating to care received at_____to the following person(s), facilities, and/or agencies at the location/facility listed below for the purpose(s) indicated:

Person/Facility/Address	Person/Facility/Address	Person/Facility/Address
_____ (Name)	_____ (Name)	_____ (Name)
_____ (Organization)	_____ (Organization)	_____ (Organization)
_____ (Street address)	_____ (Street address)	_____ (Street address)
_____ (City, State, Zip code)	_____ (City, State, Zip code)	_____ (City, State, Zip code)
_____ (Telephone number)	_____ (Telephone number)	_____ (Telephone number)

SECTION 3

List any limitations requested by the patient:

_____

_____

_____

Purpose *(check the appropriate box)*

⎦ Medical Care
⎦ Care Planning/Continuity of Care
⎦ Resource Planning
⎦ Education and Support
⎦ Other (please specify)
_____
_____

Number of discussions authorized:

⎦ One
⎦ Unlimited
(As necessary to serve purpose)

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AUTHORIZATION FOR VERBAL COMMUNICATION OF SPECIFICALLY PROTECTED INFORMATION

I understand that the following types of information will not be discussed unless I have initialed the appropriate line:

SECTION 4

I authorize discussion of the specific categories of information that I have *INITIALED* below:

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

_____Genetic screening test results **(SPECIFY TYPE OF TEST)** _____

_____ Alcohol and Drug Abuse 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 OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

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
_____ Sexually Transmitted Diseases

SECTION 5

I understand that:

- I may withdraw my authorization prior to the disclosure. 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 per this authorization, if re-disclosed by the recipient, is no longer protected by Dana-Farber Cancer Institute/Brigham & Women's Hospital.
- I understand that this authorization will automatically expire in 90 days from the date below, or for the duration of treatment, unless specified as follows. _____

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:_____

CLINICIAN INFORMATION:

Print Name:_____Date: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Print Name of Legal Representative: _____

Relationship of representative to patient: _____