



## 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](http://www.dana-farber.org/privacy)

#### Section 5

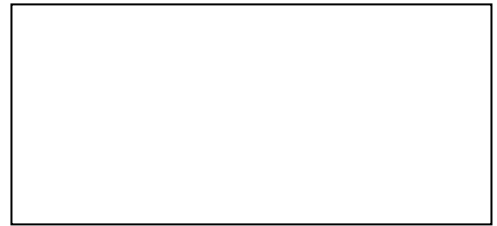
- The patient whose PHI is being reviewed must sign and date the authorization, OR the Authorized Representative of the patient must sign and date the authorization.
  - A physical signature is required in order for the form to be valid.
  - If the Authorized Representative of the patient is a Guardian, 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, 4<sup>th</sup> Floor  
Boston, MA 02210

Fax: 617-632-2020

Email: [DFCIHIS\\_ScanningDocuments@dfci.harvard.edu](mailto:DFCIHIS_ScanningDocuments@dfci.harvard.edu)



**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)**

**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

VERBAL ONLY

**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: \_\_\_\_\_