Authorization for Release of Protected or Privileged Health Information

Section 1 – Patient Information

DATE OF BIRTH____________________ **MEDICAL RECORD NUMBER**_______________________

Patient Name: ____
(Last) (First) (Middle Initial)

Patient E-Mail Address: ____

Patient Address: ____

____

Patient Telephone __________________________work/home/cell

Preferred method to receive medical records: ☐ Secure email ☐ U.S. Mail ☐Fax ☐Patient Gateway
(**Please select one delivery method)**

Section 2 – Requester Information

Dana-Farber Cancer Institute and Brigham and Women's Hospital are members of an Organized Health Care Arrangement, as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This means that Dana-Farber and Brigham and Women's are separately responsible for releasing medical records for their respective patients. If either Dana-Farber or Brigham and Women's receive a request for the release of the other hospital's records, the request will be forwarded to the appropriate hospital to respond to the request.

I,________________________________, do hereby authorize Dana-Farber Cancer Institute to release my protected health information, including copies of my medical records to the following person(s) at the location/facility listed below for the purpose(s) as indicated:

____
(Name of authorized recipient)

____
(mailing address)

____
(FAX number)

Purpose:

☐Medical Care
☐Legal Matter*
☐Insurance *
☐Personal *
☐School
☐Disability
☐Other*:_____________

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

Section 3

☐ Yawkey/Dana ☐ DFCI @ Satellite _________________________________ ☐ Inpatient

Information to be Released: ***(Please check the appropriate box(es) for the following notes and/or reports and provide dates):***

☐Entire Medical Record

☐Clinic Visit ______________________________

☐Discharge summary ____________________

☐Radiology/Imaging ____________________

☐CD ☐ Films ☐Report

☐ Pathology___________________________________

☐ Radiation___________________________________

☐ Lab____

☐ Operative___________________________________

☐ Other (please specify)________________________

☐ Medical Record Abstract *(e.g. Discharge Summary, History & Physical, Operative, Pathology, and Test Reports)*

Section 4

If Applicable: 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 DATE(S) if known: ____

______Genetic test results (excludes therapeutic genetic tests) (SPECIFY TYPE OF TEST IF KNOWN) _________________________

______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.)

Confidential Details of:

______Psychiatric Health (mental health notes 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 revoke my authorization at any time by submitting a written request to the Director of Health Information Services at Dana-Farber. The revocation will be effective except for the following:
  - Any action that has been taken in reliance on this authorization before it was revoked.
  - If the authorization is obtained as a condition of obtaining insurance coverage, to the extent that 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 redisclosed by the recipient, is no longer protected by Dana-Farber Cancer Institute.
- I understand that this authorization will automatically expire 6 months from the date it was signed.
  _____________ Please provide an expiration date in the space to the left if you wish to have this authorization remain valid longer than 6 months.

I have carefully read and understand the above. My questions about this authorization form have been answered. This authorization is voluntary.

Patient's Signature:_____________________________________Date/Time: ____________________

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/Time: ___________________

Print Name: ____

Relationship of representative to patient: ____

HIS Use Only:
Type of ID:__________________________ID **Verified** (circle): Y / N **Date:**_____/_____/_______ **Time**: ____________
HIS USE: Dates of Requested Info____/____/______to_____/____/_______# Pages Given to Pt_________Initials:__________________