Authorization to Release Protected Health Information

INSTRUCTIONS:

SECTION 1
➢ PATIENT DEMOGRAPHICS

SECTION 2
➢ RECIPIENT OF MEDICAL RECORDS
   • SELECT PURPOSE

SECTION 3
➢ SELECT MEDICAL RECORDS TO BE RELEASED
   • INDICATE DATES OF TREATMENT

SECTION 4
➢ Privileged/Sensitive Information – TO HAVE THIS INFORMATION RELEASED, INITIAL AS APPROPRIATE.
   • For more information on Dana-Farber’s privacy policies, please visit www.dana-farber.org/privacy

SECTION 5
➢ PATIENT MUST SIGN AND DATE
   • A physical signature is required
   • Legal documentation is required to sign on behalf of patient
     • Acceptable forms: Durable Power of Attorney; Probate court appointed Personal Representative

Return this form by mail or email:
DFCI - Health Information Services
Correspondence Department
27 Drydock Ave, 4th Floor
Boston, MA 02210

correspondence_roi@dfci.harvard.edu

Return this form by fax:
For CIOX - 3rd Party Medical Records Vendor only:
   • 770-810-4161

For FMLA or Disability requests only:
   • 617-394-2647
Authorization for Release of Protected or Privileged Health Information

Section 1

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

Section 2

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)

*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

DFCI @ DFCI @ DFCI @ DFCI @
□ Yawkey/Dana □ St. Elizabeth’s □ Milford Regional □ Londonderry □ South Shore □ Inpatient

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

□ Entire Medical Record □ Pathology ______________________________

□ Clinic Visit ______________________________ □ Radiation ______________________________

□ Discharge summary ______________________________ □ Lab ______________________________

□ Radiology/Imaging ______________________________ □ Operative ______________________________

□ CD □ Films □ Report □ 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 disclosed 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: __________________________

Revised 01.04.17