Beth Israel Deaconess Medical Center
330 Brookline Avenue / Medical Records
Shapiro E/CC-010 Boston, MA 02215

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PERMISSION TO SHARE INFORMATION

A. Patient's Name (*please print*):	Date of Birth: _____ / _____ / _____ month day year	Medical Record Number (*if known*):
Address:	Telephone Number:	Social Security Number (*last 4 digits*):

B. Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

MR0176

From / Between (Circle):	**To / Between** (Circle):
Name: _____	Name: _____
Address: _____	Address: _____
FAX Number: _____	FAX Number: _____
Telephone Number: _____	Telephone Number: _____

C. Reason for Release of Records: _____ A copying service fee will be charged; including for records that are sent directly to a patient. (Please see Instructions on reverse side)

D. Information to be released for treatment dates: From ____ /____ /____ through ____ /____ /____

E. Documents to be released: **Please check YES or NO for each of the following options**

YES	NO		YES	NO	
☐	☐	**Medical Records Abstract** (i.e., History & Physical, Operative / Procedure Reports, Clinical / Office Notes, Discharge Summary, All Diagnostic Test results)	☐	☐	Radiology Reports
			☐	☐	Laboratory Reports
☐	☐	Progress Notes	☐	☐	Pathology Reports
☐	☐	Discharge Summary	☐	☐	Operative Notes
☐	☐	Photographs / Videos	☐	☐	Entire Medical Record
☐	☐	X-Rays / X-Ray Reports (please specify): _____	Other (please specify): _____		

F. Privileged or Specifically Protected Information: **Please check YES or NO for each of the following questions**

YES	NO		YES	NO	
☐	☐	Alcohol or Drug Abuse Treatment	☐	☐	HIV / AIDS diagnosis and/or treatment: I specifically give permission to share information in my record about my HIV / AIDS diagnosis and/or treatment information. Initial here to specifically authorize its release _____ as required by M.G.L. c.111, § 70F.
☐	☐	Sexually Transmitted Diseases			
☐	☐	Domestic Violence Victim's Counseling			
☐	☐	Sexual Assault Victim's Counseling			
☐	☐	Communication between patient and Social Worker			
☐	☐	Psychiatric Health – mental health information including communication between a patient and a Psychiatrist, licensed Psychologist, and Psychiatric Clinical Nurse Specialist	☐	☐	Genetics Testing: I specifically give permission to share Information in my record about my genetics testing (excludes therapeutic genetic tests). Initial here to specifically authorize its release _____ as required by M.G.L. c.111, § 70G.

G. I understand and agree that:

• The information which I authorize for release may be re-sent and no longer protected by federal privacy regulations	• I may take back this authorization at any time by notifying the physician / hospital / clinic / organization from whom I am requesting this information, provided that the information has not already been released
• I will be charged a fee for information that is sent directly to me	• This authorization is voluntary
• I decline the opportunity to inspect or copy the information released	• My treatment will not be conditioned on the completion of this authorization.
• I have received a copy of this authorization	• My questions about this authorization form have been answered

H. This authorization expires 12 months from the date it was signed OR as specified: ____ /____ /____
If not specified, this authorization will expire 12 months from the date it was received.

I. X_____ _____ **OR**
Patient's Signature Print Name

X_____ _____ **and** _____
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ____/____/____ Time: __ __ : __ __ ◯ a.m. ◯ p.m.

Distribution: **White = Medical Record** • **Canary = Patient** **[Directions: Please See the Reverse Side]**

Instructions to Complete the Authorization to Release Protected Health Information

Please follow these instructions carefully when completing the authorization form. The form must be entirely completed. Failure to do so may result in a delay in processing this request to release your medical record information. Please follow these steps and leave no box blank:

A. Patient Name, Address, Date of Birth, Medical Record Number, Telephone Number and Social Security Number: Print the name, address, date of birth, medical record number (if known), telephone number and the *last 4 digits* of the Social Security Number of the patient to whose protected health information ("medical record") is being released.

B. Permission to Share: Note: Faxing service is available for urgent medical care only.
From / Between - Print the name, address, fax number and telephone number of the organization or individual from whom the medical record is requested. Circle **Between** if you want the information shared between the two parties.

To / Between - Print the name, address, fax number and telephone number of the organization or individual who will receive the medical record. Circle **Between** if you want the information shared between the two parties.

C. Copying Service Fee for Records: If you wish to have records sent to you directly; you will be charged a fee and will be billed by invoice. If you have questions about the copying service fee for records sent directly to you, please contact the BIDMC Correspondence Manager at 781-234-0851, Monday – Friday 8:30 AM – 5:00 PM.

By way of example: The size of a medical record varies according to length of stay and/or number of visits to the hospital. We estimate the average cost for a length of stay to be as follows:

- Average copying service fee for a medical record abstract is $75.00
- Average copying service fee for an entire medical record is $600.00

D. Treatment Dates: Insert the treatment date or date range of the medical record you are requesting to be released.

E. Documents to be Released: Check each box YES or NO to identify the type of document you are requesting to be released. Please fill-in all boxes.

F. Privileged or Specifically Protected Information: Check each box YES or NO to indicate each type of information you are authorizing for release. Please fill-in all boxes. If you had testing, diagnosis or treatment for any condition(s) as described under the "specifically protected" section, it is required that you place your initials in front of the section(s) that describes the type of information to be released.

G. Understanding/Agreement: Please read the important information in this section.

H. Expiration Date: Insert the expiration date. If not specified; then this authorization will be valid for 12 months.

I. Patient or Authorized Representative Signature: The patient whose medical record is being released must sign and date the authorization OR the Authorized Representative of the patient to whom the medical record pertains must sign and date the authorization.

Please note: If the individual signing the authorization form is a Guardian, Executor of the Estate, Healthcare Proxy or Power of Attorney for the patient, that person must submit a copy of the appropriate legal document, which proves authority to act on behalf of the patient. This must accompany the authorization form.

Complete if record is released to patient or authorized representative of the patient

For BIDMC Use Only

Date: _____ /_____ /_____

Information Released By: _____ Contact Number: _____

Clinic / Office: _____ Number of Pages: _____

Patient / Authorized Representative Identification Verified:

☐ License ☐ State ID ☐ Passport ☐ Other Photo ID: _____

Guardian, Executor of the Estate, Healthcare Proxy or Power of Attorney for the patient:

☐ N/A ☐ Copy of legal document (authority to act on behalf of the patient) received