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| **Brigham & Women's Faulkner Hospital**<br>**1153 Centre St**<br>**Boston, MA**<br>**02130-3446**<br>**617-983-7000** | **Name:**<br><br>**CSN #:**<br><br>**Date of Service:** |

I authorize Partners HealthCare System, Inc. (Partners Health Care) and my health care providers, as defined below, to send my protected or privileged health information (e.g.: a clinical summary) in connection with my hospital admission, emergency department or outpatient visit to my present and future health care providers (e.g.: primary care provider, referring provider, and/or providers I am referred to see) who participate in the Massachusetts Health Information Highway ("Mass HIway") or Epic Health Information Exchange ("Care Everywhere") to help coordinate my care.

**I specifically authorize the release of any of the following health information if it is in my medical record:**

- HIV test results and treatment
- Genetic Screening Test Results
- Substance Use Disorder 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 BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.
- Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC)
- Confidential Communications with a Licensed Social Worker
- Details of Domestic Violence Victims' Counseling
- Details of Sexual Assault Counseling

**I understand that:**

- This authorization is voluntary. My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form.
- I may cancel this authorization, except to the extent that Partners Health Care or my health care providers have already relied upon it (for example, once information is released, it will not be retrieved). To cancel this authorization, I must contact a Partners Health Care site privacy office (see the Partner HealthCare Privacy Notice for contact information).
- This authorization will expire in one week.
- I have a right to receive a list of the entities that have received my protected substance use disorder treatment records as a result of this consent upon written request. I must contact the Privacy Office for the entity where I received substance use treatment to make this request.

- Partners HealthCare has developed an electronic health record for patient care. This electronic health record is used by:

    - Partners HealthCare, connected organizations, and health care providers, and
    - Other non-Partners health care providers, such as Dana-Farber Cancer Institute (DFCI), and some community physicians and physician groups.
- The term “my health care providers” as used in this form includes all of the above users of the Partners HealthCare electronic health record.

My questions about this authorization form have been answered.

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| Patient Signature: |
| When the patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required. |
| Signature of Representative: |