

BRIGHAM HEALTH



AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner

BWFH Health Information Management

1153 Centre Street Jamaica Plain, Ma 02130 Phone: 617-983-7960 Fax: 617-983-7805

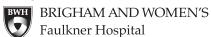
www.brighamandwomensfaulkner.org/medicalrecords

For copies of radiology images or films, contact 617-983-7169 / Fax 617-983-4424

A. PATIENT INFORMATION			
PATIENT NAME:	PATIENT DATE OF BIRTH:		
PATIENT MEDICAL RECORD #			
PATIENT ADDRESS: STREET:	APT. #:		
CITY:	STATE: ZIP CODE:		
TELEPHONE CONTACT #: DAY: ()	EVENING: ()		
B. PERMISSION TO SHARE: I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.			
FROM: (e.g. hospital, clinic, or provider name):	TO: (e.g. to whom you would like the information sent):		
Name:	☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information		
Address:	below to indicate where you would like the information sent:		
Talambana Niumban	Name:		
Telephone Number:	Address:		
	Telephone Number:		
PURPOSE: (check the appropriate box)			
☐ Medical Care ☐ Personal*	SEND BY: □ Partners Patient Gateway (if available)		
☐ Insurance* ☐ School	☐ Secure Email (provide email address below)		
☐ Legal Matter* ☐ Other (please specify)*	Patient Email Address:		
<u></u>	☐ Fax (provide fax number):		
* Copying fees may apply			
C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):			
☐ Medical Record Abstract/dates	Radiation Reports/dates		
(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)	Radiology Reports/dates		
Clinic Visit Notes/dates	☐ Photographs/dates (costs may apply)		
☐ Discharge Summary/dates	Billing Records/dates		
☐ Lab Reports/dates	Other (please specify below and include dates)		
Operative Reports/dates			
☐ Pathology Reports/dates			

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Clinic/Office: _____ Pick-up Identification:



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D.	Please	check YES to indicate if you give permission to release the following information if present in your record:		
	Yes	HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.) SPECIFY DATES		
	Yes	Genetic Screening test results (SPECIFY TYPE OF TEST)		
	Yes	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 BY 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.		
	Yes	Other(s): Please List		
	Yes	Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)		
	Yes	Confidential Communications with a Licensed Social Worker		
	Yes	Details of Domestic Violence Victims' Counseling		
	Yes	Details of Sexual Assault Counseling		
E.	l unde	rstand and agree that:		
		rtners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that we protecting its confidentiality at PHS may or may not protect this information once it has been released to the cipient		
	• Th	is authorization is voluntary		
 My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do form 		r treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this m		
		may cancel this authorization at any time by submitting a written request to the Department or Office where I riginally submitted it, except:		
		 if PHS has already relied upon it (for example, once information is released, it will not be retrieved) if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself 		
	• Th	is authorization will automatically expire 6 months from the date signed unless otherwise specified:		
	• My	questions about this authorization form have been answered		
\triangleright	Patien	t's Signature: > Date:		
	Print N	Name:		
Wh	en patie	ent is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal tive is required.		
Sig	nature	of Legal Representative: Date:		
Pri	nt Nam	e: Relationship of representative to patient:		
		For Internal Use Only		
Info	rmation R	eleased/Reviewed By: Date		

License _____ State ID _____ Passport _____ Other Photo ID ___