Tufts Medical Center

Authorization to Disclose Protected Health Information

Dear Patient:
Please complete this form and return it to: ***Tufts Medical Center, Health Information Management Box 999, 800 Washington Street Boston, MA 02111***, to use or disclose your protected health information as described below.

Patient Information:
Medical Record # _____
Name: _____ Date of Birth: _____
Address:_____
Area Code/Telephone #:_____ Alternate #:_____

Purpose of the Requested Use or Disclosure:
Medical Treatment or Transfer: _____ Legal: _____ Insurance: _____
Personal: _____Other (please specify): _____

Specific Description of Information (must include date(s)):
Date(s) of Treatment: _____
____ ER Record
____ Discharge Summary _____ Pathology Reports
____ Operative Report _____ Lab Reports
____ Clinic Visit Note _____ X-Ray/MRI/Cat Scan Reports
____ Complete Record _____ Therapy (Physical/Occupational)
____ Abstract of Record: (e.g. History & Physical, Operative & Discharge Reports, Consults, Lab Reports,
ER Reports – specify elements to be released) _____
____Other: (please specify) _____

Release of Specifically Protected Health Information
If the information described above includes information in any category below*, I specifically authorize the use or disclosure of such information. Please indicate the specific information to be used or disclosed and sign where indicated:*

____ **HIV/AIDS testing/test results** (patient authorization required for each release request)
Specify date: _____

_____ _____
Signature of Patient/Legal Representative Date
Relationship to Patient or Authority to Act on Patients' behalf: _____

____ **Genetic testing/test results**
Specify date: _____
Specify type of test: _____ _____

_____ _____
Signature of Patient/Legal Representative Date
Relationship to Patient or Authority to Act on Patients' behalf: _____

Information identified in any category below:
Alcohol and drug abuse records S*pecify dates*: _____
Mental health treatment/psychotherapy
Sexual assault counseling
Social service counseling/therapy
Venereal diseases/sexually-transmitted diseases

_____ _____
Signature of Patient/Legal Representative Date
Relationship to Patient or Authority to Act on Patients' behalf: _____

To Whom Information Will Be Disclosed. I authorize Tufts Medical Center to disclose copies of my protected health information described above to: *(complete name and mailing address)*
Name: _____
Street Address: _____City_____
State _____ Zip Code____ Attention: _____

Expiration. This authorization will expire automatically in 6 months or on the following date or event that relates to me or the purpose of the use or disclosure: _____

Specific Understandings
I understand that I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do it won't have any affect on actions taken by Tufts Medical Center before they received the revocation.

I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it.

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

_____ _____
Signature of Patient/Legal Representative Date
Relationship to Patient or Authority to Act on Patient's Behalf: _____