Mail or Fax to:
Release of Information

Boston Maxillofacial Prosthetics
41 West St., Fl 3
Boston, MA 02111

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

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

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):

Name: _____

Address: _____

_____

Telephone Number: _____

PURPOSE: (check the appropriate box)

- ☐ Medical Care
- ☐ Insurance*
- ☐ Legal Matter*
- ☐ Personal*
- ☐ School
- ☐ Other (please specify)* _____

* Copying fees may apply

TO: (e.g. to whom you would like the information sent):

☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent:

Name: _____

Address: _____

_____

Telephone Number: _____

SEND BY:

- ☐ RXNT Patient Gateway (if available)
- ☐ Secure Email (provide email address (below):
  Patient Email Address: _____
- ☐ Paper Copy via Mail
- ☐ Fax (provide fax number): _____

C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

- ☐ Medical Record Abstract/dates _____
  (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ☐ Clinic Visit Notes/dates _____
- ☐ Discharge Summary/dates _____
- ☐ Lab Reports/dates _____
- ☐ Operative Reports/dates _____
- ☐ Pathology Reports/dates _____
- ☐ Radiation Reports/dates _____
- ☐ Radiology Reports/dates _____
- ☐ Photographs/dates (costs may apply) _____
- ☐ Billing Records/dates _____
- ☐ Other *(please specify below and include dates)* _____

_____

_____

_____

_____

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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. I understand and agree that:

- Partners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHS may or may not protect this information once it has been released to the recipient
- 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 at any time by submitting a written request to the Department or Office where I originally 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
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
- I understand that if Partners maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **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:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date _____

Clinic/Office: _____

Pick-up Identification:

_____ License _____ State ID _____ Passport _____ Other Photo ID _____