MITMedical
Mental Health Service
77 Massachusetts Ave., E23-368
Cambridge, MA 02139-4307
Phone: 617-253-2916 • Fax: 877-932-6537

Authorization for Release of Protected Health Information (Mental Health Record) by MIT Medical

Important information about releasing patient medical records

MIT Medical recognizes the patient's right to confidentiality of protected health information as set forth in federal and Massachusetts state law. You should be aware of these guidelines when requesting medical records.

State and federal laws recognize the need for written authorization.

All releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information on care provided after the date of the patient's signature, unless you (the patient or personal representative) specify release of future records of a specific test, specific clinic appointment, etc.

If the patient is 18 years or <u>older</u>, the patient *must* sign the release unless:

1. the patient is incompetent,
2. the patient is disabled and cannot sign the form,
   or
3. the patient is deceased. (The surviving spouse or legal representative with legal proof must sign the authorization for release of the deceased patient's records.)

If the patient is 18 years or <u>younger</u>, the patient *must* sign the release if:

1. the patient is an MIT student, regardless of age
2. the patient is 14 years or older **and** the records involve treatment for mental illness, alcohol or drug abuse/treatment, domestic/sexual assault, or AIDS testing
   or
3. the patient's records for release include an abortion procedure.

Please read before completing the form below:

a. This form must be completed in its entirety and signed by the patient or personal representative to be a valid authorization. Incorrect or incomplete forms will not be processed. **Anyone other than the patient who signs this authorization for release of records must state his or her relationship to the patient and provide proof of legal authority to release the records.**
b. To obtain a copy of test results, procedures and/or notes that were done at another health care organization, please contact that facility directly.

---

1. <u>PATIENT INFORMATION</u>

Patient last name _____ First name _____ MI _____ Date of birth_____

Patient former name (if any) _____ MIT ID _____

Patient address _____ Patient e-mail _____
Number Street City State Zip

Patient home phone _____ Work phone _____ Cell phone _____

2. <u>RECIPIENT AUTHORIZATION</u>

I, _____ do hereby authorize _____ to release a copy of my mental health record or verbal information to person or facility below.
Patient name or representative

Name of person or facility to receive medical information: _____ Phone _____

Address _____

3. INFORMATION TO BE RELEASED *(Note: requests for release of psychotherapy notes cannot be combined with any other type of request.)*

☐ **Verbal communication only** regarding _____ ☐Visit note(s): _____
Specific topic or visit date(s) Specific provider or visit date(s)

☐ My entire mental health record ☐ Only those portions pertaining to: _____
Specific provider name and/or dates of treatment

4. PURPOSE OF INFORMATION RELEASE

☐Further mental health care ☐ Payment of insurance claim ☐ Legal investigation ☐ Applying for insurance
☐ Vocational rehab, evaluation ☐ Disability determination ☐ At the request of the individual
☐ Other (specify): _____

5. INCLUSION OF PRIVILEGED INFORMATION

- I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by federal regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 §70, such information will be included in this disclosure.

If you do **not** wish to have released any of the categories of information described in the paragraph above, please specify _____

_____

_____

6. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to MIT Medical's Mental Health Service, except to the extent that Mental Health Service has already completed action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the MIT Medical from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

7. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____ _____
Signature Date

If signed by a personal representative: (a) print your name: _____

(b) indicate your relationship to the patient and/or reason and legal authority for signing:

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased

Once complete, please send to MIT Student Mental Health and Counseling Services:
77 Massachusetts Ave., E23-368
Cambridge, MA 02139-4307
Fax: 877-932-6537

For MIT Mental Health use only

Date received: _____ **Received by:** _____ **ID provided:**_____ **MRN:** _____

Date released: _____ **Processed by:** _____ ☐ **Sent by FedEx** ☐ **Picked up in person**