

### 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 older, 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 younger, 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. The MIT Medical Records Service does not fax records.
- c. There is no fee for records released directly to other health care providers. However, if you wish to have your information disclosed to you directly, you will be charged a fee of \$0.65 per page for the first 100 pages and \$0.35 per page for each page thereafter. Payment may be made with personal check, money order, Visa or MasterCard. Patients may view their medical record on screen at no charge by making an appointment with the Medical Records Service (617-253-4906).
- d. When copies of the medical record are requested for parties other than the patient or another health care provider (e.g., legal or insurance firms), the recipient will be charged a base fee of \$20 in addition to the charges detailed in paragraph (c) above.
- e. If you wish to complete this form in person at MIT Medical, make sure to bring two forms of ID. One must be a government ID (driver's license, state ID, or passport). If you have any questions or need more information, please call the Medical Records Correspondence Service at 617-253-4906.
- f. To obtain a copy of test results, procedures and/or notes that were done at another health care organization, please contact that facility directly.

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*Completing all sections of this form will facilitate timely release of your information.*

**1. PATIENT INFORMATION**

Patient last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth \_\_\_\_\_  
Patient former name (if any) \_\_\_\_\_ MIT ID \_\_\_\_\_  
Patient address \_\_\_\_\_ Patient e-mail \_\_\_\_\_  
Street City State Zip  
Patient home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**2. RECIPIENT AUTHORIZATION**

I, \_\_\_\_\_, do hereby authorize \_\_\_\_\_ to release a copy of my medical information  
Provider or service  
to the person or facility below. Note: MIT Medical does not fax records. A fee may be required for release of records—see (c) above.

Name of person or facility to receive medical information: \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

**3. TYPE OF MIT MEDICAL INFORMATION TO BE RELEASED** — please check all that apply.

**a.  A portion of my medical record:**

Check the portion(s) of your medical record you wish to release and write the date of the visit(s) or test(s).

- |  |  |
|--|--|
| <input type="checkbox"/> Immunizations: _____<br>Date(s) of immunization                                     | <input type="checkbox"/> Visit notes reports: _____<br>Date(s) of visits |
| <input type="checkbox"/> X-ray reports: _____<br>Date(s) of X-ray ( <b>contact X-ray Service for films</b> ) | <input type="checkbox"/> Lab reports: _____<br>Date(s) of lab test       |
| <input type="checkbox"/> EKG/echoes: _____<br>Date(s) of EKG/echo  | <input type="checkbox"/> Mammograms: _____<br>Date(s) of mammogram       |
| <input type="checkbox"/> Pathology reports: _____<br>Date(s) of report                                       | <input type="checkbox"/> Stress tests: _____<br>Date(s) of stress test   |
| <input type="checkbox"/> Other: _____<br>Date(s) of procedure  |  |

**b.  My entire MIT Medical record**

**c.  Verbal communication only**

Specific medical topic or MIT Medical visit(s) that may be discussed: \_\_\_\_\_

**4. PURPOSE OF INFORMATION RELEASE**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Further medical care         | <input type="checkbox"/> Payment of insurance claim | <input type="checkbox"/> At the request of the individual | <input type="checkbox"/> Applying for insurance |
| <input type="checkbox"/> Vocational rehab, evaluation | <input type="checkbox"/> Disability determination   | <input type="checkbox"/> Legal investigation              | <input type="checkbox"/> Changing PCP           |
| <input type="checkbox"/> 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: \_\_\_\_\_

**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 the MIT Medical Records Service, except to the extent that Medical Records 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

<b>For MIT Medical use only</b>			
Date received: _____	Received by: _____	ID provided: _____	MRN: _____
Date released: _____	Processed by: _____	<input type="checkbox"/> Sent by FedEx <input type="checkbox"/> Picked up in person	