



Mental Health Service  
 77 Massachusetts Ave., E23-368  
 Cambridge, MA 02139-4307  
 Phone: 617-253-2916 - Fax: 617-253-0162

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

**DISCLOSURE OF PROTECTED MENTAL HEALTH INFORMATION (PHI) TO MIT MEDICAL**

**1. PATIENT INFORMATION**

Patient last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Patient former name (if any) \_\_\_\_\_ Patient address \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ e-mail address: \_\_\_\_\_

**2. INFORMATION TO BE DISCLOSED**

I hereby authorize \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ to disclose a copy of my:

- Admission Notes \_\_\_\_\_  Progress Notes \_\_\_\_\_  Office Notes \_\_\_\_\_  Lab Reports \_\_\_\_\_
- Hist & Phys \_\_\_\_\_  Consult Report \_\_\_\_\_  Emergency Service Report \_\_\_\_\_
- Entire Mental Health Record  Other \_\_\_\_\_

**3. RECIPIENT AUTHORIZATION**

To the attention of: \_\_\_\_\_ at MIT Medical Mental Health, 77 Massachusetts Ave E23-368  
 for further medical care.

**4. RELEASE OF PRIVILEGE INFORMATION**

- Abortion  AIDS/ARC  HIV Testing and related information
- Sexually Transmitted Diseases (STD)  Genetic Testing  Domestic/Sexual abuse
- Developmental disabilities  Other Specify \_\_\_\_\_

**5. 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.

**6. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:** \_\_\_\_\_

Signature Date

Personal representative, print name: \_\_\_\_\_

Printed name of personal representative

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing:

- Patient is:  minor  incompetent  disabled  deceased  
 Legal authority:  parent  legal guardian  next of kin of deceased