MIT Medical
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) 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
☐ Sexually Transmitted Diseases (STD)
☐ Developmental disabilities
☐ AIDS/ARC
☐ Genetic Testing
☐ Other Specify_____
☐ HIV Testing and related information
☐ Domestic/Sexual abuse

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	

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