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

Medical Record Service
77 Massachusetts Ave., E23-023
Cambridge, MA 02139-4307
Phone: 617-253-4906 • Fax: 617-258-0884

1. Patient Information

Patient last name ___________________________ First name _________________________ MI ______ Date of birth __________________________

Patient former name (if any) ____ Patient e-mail ________________________________

Patient address ____
Street City State Zip

Patient home phone _______________________ Work phone ________________________ Cell phone ______________________________________

2. Information to be Disclosed

I hereby authorize ____ **at** ____
Provider name Provider address

____ _____________________________________
City, state, ZIP Provider phone number

to disclose a copy of the following portion(s) of my medical record to MIT Medical:

☐ Admission notes: _______________ ☐ Progress notes: __________________ ☐ Office notes:____________ ☐ Stress tests:______________
☐ EKGs/echo: ___________________ ☐ Immunizations: ___________________ ☐ Lab reports: ____________ ☐ Mammogram: ____________
☐ Pathology reports: ______________ ☐ X-ray reports: ____________________ ☐ H&P:_________________ ☐ Op report: ______________
☐ Consult report: _________________ ☐ Emergency service report: __________ ☐ Entire medical record
☐ Other ____

3. Recipient Authorization

To the attention of _______________________________________ at MIT Medical

☐ 77 Massachusetts Ave., E23 - _______ Cambridge, Mass. 02139 ☐ 244 Wood St., Bldg V-110, Lexington, MA 02421

Phone # _____________________________ Fax # ______________________________ for further medical care.

4. Release of Privileged Information

☐ Mental health ☐ Alcoholism ☐ Substance abuse ☐ Abortion
☐ HIV testing and related information ☐ Sexually transmitted diseases ☐ 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 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 personal representative, print name: ____

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

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