



Medical Records Service
 77 Massachusetts Ave., E23-023
 Cambridge, MA 02139-4307
 Phone: 617-253-4906

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

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: _____ Hist & Phys: _____ Op report: _____
- Consult report: _____ Emergency service report: _____ Entire medical record
- Other: _____

3. RECIPIENT AUTHORIZATION

To the attention of _____ at MIT Medical (check location):

- 77 Massachusetts Ave., Room E23- _____
 Cambridge, MA 01239
- 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.

6. 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