MIT MEDICAL DEPARTMENT

Authorization for Use and Disclosure of Protected Health Information

How to Complete this Form

The "Authorization for Use and Disclosure of Protected Health Information" form must be completed in its entirety and signed by the patient (you) or personal representative to be a valid authorization. Download the form and print it. Incorrect or incomplete forms will not be accepted. The steps outlined below are provided to assist you with the proper completion of this form. Note that there may be a fee associated with the release of the information. If you wish to complete this form in person at MIT Medical, make sure to bring with you a government ID (driver's license, State ID or a passport). If you have any questions or need more information please contact the MIT Medical Record Correspondence Service at (617) 253-4906.

Note: *To obtain a copy of a test result, procedure and/or notes that was done at another health care organization, please contact that organization directly*.

- **Item #1,** please neatly print or type the patient's (your) name, date of birth, former name if applicable, MIT ID or SS number, address, phone number, e-mail address, home, work and/or cellular telephone number in the section indicated.
- **Item #2,** please specify the information to be disclosed, by checking the box for entire medical record or the box for only those portions of the medical record pertaining to: the information must be identified in a meaningful fashion. For example, *note (s), immunization or lab results from Dr. X on January 2004*.
- **Item #3,** please enter the name and address of the person or organization authorized to receive the patient (your) health information.
- **Item #4,** please check off all of the boxes that applies.
- **Item #5,** please check off the appropriate box for reason for disclosure.
- **Item #6,** please provide the date when the authorization will expire, no more than six month form the date of signature. This date must be the same as the date of signature on the authorization form.
- **Item #7,** please read this section as it informs you of your privacy protection regarding the release your health information.
- **Item #8,** the patient (you) or personal representative must sign and date the form. If the personal representative is signing on behalf of the patient, then the personal representative must also print his/her full name and check off the appropriate box for relationship to the patient.

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Medical Records Service
77 Mass Avenue, Cambridge, MA 02139
Building E23-023

Tel: (617) 253-4906
Fax: (617) 258-0884
Email: medcor@med.mit.edu

1 **Patient last name:** ___________________________ **First name:** ________________________ **Middle initial:** ______ **D.O.B**.:_____________________

Patient former name: ___________________________________ **MIT ID/SSN:** _______________________ **MRN**: ______________________________

Patient Address: ____ **Patient e-mail**: ______________________________

Patient home phone #:_______________________ **Work phone #:**____________________**Cell phone #:**______________________________________

2 **I authorize the MIT Medical Department to release or disclose (Information to be released, check one)**

☐ My entire medical record ☐ Only those portions pertaining to (be specific, include provider name and date(s) of treatment, if applicable):
____

3 **Disclosed records to:** Name/Facility: ____ Address: ____

____ Attention: ____

4 **Reason for disclosure:**

☐ Further medical care ☐ Payment of insurance claim ☐ Legal investigation ☐ Applying for insurance
☐ Vocational rehab, evaluation ☐ Disability determination ☐ At the request of the individual
☐ Other – specify: ____

5 **Under Massachusetts state law MIT cannot release certain information unless you give us special permission to release it.**

☐ Abortion ☐ AIDS/ARC ☐ Alcoholism ☐ Developmental disabilities
☐ Domestic/Sexual abuse ☐ Genetic Testing ☐ HIV Testing and related information ☐ Mental Health
☐ Privileged information ☐ Substance abuse ☐ Sexually Transmitted Diseases (STD)
☐ Other – Specify____

6 **This authorization is valid for PHI disclosures to the recipient above for a period of six months, and it automatically expires in six months from __________ (same date as date signed.) I understand that I am responsible to notify Medical Records Service of visit(s) that I wish to have disclosed to this recipient. I understand that I may revoke this authorization by providing a written statement to the MIT Medical Records Service, except to the extent that MIT Medical Records Service has already completed the action on it.**

7 **I understand that protected health information released pursuant to this authorization may be re-disclosed by the recipient(s) on this form to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the MIT Medical Department from all legal responsibilities and liabilities that may arise from the release of the information.**

8 **Signature of patient/personal representative** ____**Date** ____________________________

Personal Representative. Please print name ____**Date** ____________________________

If signed by anyone other than the patient, state the relationship and/or reason and legal authority to do so:

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

9 **Signature of witness** ____**Date** ___________________________

For MIT Medical use:
Date received __________________ I.D. provided _______________________________Date released _________________________
Processed by _______________________________ ☐ Sent by mail ☐ Picked up in person ☐ Sent by Fax

Important fine print about releasing patient medical records

The MIT Medical Department recognizes the patient's right to confidentiality of medical records as set forth in Federal and Massachusetts state law. You should be aware of these guidelines when requesting medical records.

Federal and Massachusetts state laws recognize the need for written authorization.
The patient may request multiple releases of the information stated on the authorization form. However, 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 state in the authorization to release 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 with legal proof or legal representative must sign to authorize release of records of the deceased patient.)

If the patient is 18 years or younger, the patient *must* sign release if:

1) the patient is an MIT student, regardless of age
2) the patient is 14 years of age or older and the records involve treatment for mental illness, alcoholism, drug dependence, or AIDS testing
3) the patient's records for release include an abortion procedure.

Anyone signing for release of records, other than the patient, must state their relationship to the patient and have available proof of legal authority to release the records.

The MIT Medical Department reserves the right to charge for copying of medical records.

*** Privileged information includes the following:**

1) Information concerning HIV/AIDS
2) Information concerning venereal disease
3) Information concerning drug or alcohol abuse
4) Communications between patients and psychotherapists or psychologists
5) Communications with social workers

Note to recipient of information:
This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

A request for records concerning visits, procedures, or surgery done at a facility other than ours may have to be requested from that facility.