HARVARD UNIVERSITY HEALTH SERVICES

Medical Records Dept	**75 Mt. Auburn Street, Cambridge, MA 02138**	**(617) 495-2055**	**Fax (617) 495-8077**
Mental Health Department	**75 Mt. Auburn Street, Cambridge, MA 02138**	**(617) 495-2042**	**Fax (617) 496-6890**
Dental Service	**75 Mt. Auburn Street, Cambridge, MA 02138**	**(617) 495-2063**	**Fax (617) 496-0562**
Business School Health Service	**Cumnock Hall, Boston, MA 02163**	**(617) 495-6455**	**Fax (617) 495-8079**
Law School Health Service	**1563 Massachusetts Ave., Cambridge, MA 02138**	**(617) 495-4414**	**Fax (617) 495-8090**
Medical Area Health Service	**275 Longwood Ave., Boston, MA 02115**	**(617) 432-1370**	**Fax (617) 432-7120**

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

- Patient's ID card number _____ Date of birth _____
- Patient's name _____
- I authorize Harvard University Health Services to disclose and/or use the above named individual's health information as described below.

  =>Person/Organization receiving the information: Name: _____
  Address (include ZIP code): _____
  =>Description of specific information to be disclosed and/or used (include dates of service): _____
  _____
  =>Purpose for use or disclosure of information: _____

THE FOLLOWING INFORMATION REQUIRES YOUR SPECIFIC SIGNATURE AND WILL BE USED AND/OR DISCLOSED ONLY IF IT IS SIGNED FOR HERE:	
X ABORTION _____	**X** SEXUAL ASSAULT _____
X AIDS/HIV[1] _____	**X** SEXUALLY TRANSMITTED DISEASE _____
X SUBSTANCE ABUSE _____	**X** GENETIC TESTING _____
X MENTAL HEALTH[2] _____	

1. I understand that this authorization is voluntary. I need not sign this form in order to ensure treatment, enrollment or eligibility of health benefits or payment for services rendered to me. I may inspect or copy the information to be used and/or disclosed.
2. I understand that if the organization receiving the information is not a health plan or health care provider, the released information might no longer be protected by Federal privacy laws and might be re-disclosed by the recipient without my authorization.
3. I understand that I have a right to revoke this authorization in writing to the Medical Records Department at any time unless it has already been acted on, and that such revocation will not affect my treatment, enrollment or eligibility of health benefits or payment for services rendered to me.
4. This authorization is valid for 90 days from the date of signing unless it has been revoked.
5. Insurance applicants: withholding or release of information may be governed by your insurance company's regulations, state law, and/or federal law.
6. I understand that if I have questions about disclosure and/or use by HUHS of my medical information, I may contact the HUHS Privacy Officer at (617) 496-1630.
7. I knowingly and voluntarily authorize HUHS to disclose and/or use the health information specified in the manner described above.

SIGN HERE: X_____ _____ _____

(Patient/legal representative signature) **(If patient is not signing, indicate representative's authority to act on patient's behalf (e.g., legal guardian)** **(today's date)**

- CHECK ONE**: [ ]**For pickup: arrange date with Medical Records **[ ]**Mail to patient **[ ]**Mail to addressee
- Patient's address:_____ Telephone: _____
- Indicate present or previous Harvard affiliation: **[ ]** Harvard College, class of _____ **[ ]** Grad School (school/year) _____
  [ ] HUGHP (latest year enrolled) _____ **[ ]** Non-HUGHP staff (latest year employed): _____ **[ ]** Other _____

H-162 3/03

[1] Including the fact that an HIV test was ordered, performed, or reported, regardless of whether the results of such tests were positive or negative.

[2] This includes documentation and analysis of any communications between me and my psychiatrist, psychologist, social worker, psychiatric nurse, mental health specialist, sexual assault counselor, domestic violence counselor, or other allied mental health or human services professional.