DANA-FARBER CANCER INSTITUTE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
MEDICAL INFORMATION REQUEST FORM

MEDICAL RECORD # _____ **DATE OF BIRTH**_____

PATIENT NAME: _____
(Last) (First) (M.I.)

PATIENT ADDRESS: _____

_____

_____

☐ I, _____, do hereby authorize release of
(*Patient Name)*
my protected health information including copies of my medical record of care received at

_____ to: **Dana-Farber Cancer Institute**
(Name of Hospital): **450 Brookline Ave.**
Boston, Ma 02215 - 5450
MD Name _____
Floor/Clinic_____
ATT: _____
FAX: _____

OR

☐ I, _____, do hereby authorize _____to release
(Patient Name) *(Name of Physician)*
my protected health information including copies of my medical record of care received by:

Dr _____ to: _____
(Physician Name) *(Name of Physician)*
_____
(Street Address)
_____
(City, State Zipcode)
_____
Phone FAX

PROTECTED HEALTH INFORMATION TO BE RELEASED ***(Please check the appropriate box(es)and provide dates of treatment):***

- ☐ Clinic visit notes _____
- ☐ Operative reports _____
- ☐ Discharge summary _____
- ☐ X-rays/Scan reports _____
- ☐ Pathology reports _____
- ☐ Radiation reports_____
- ☐ Lab reports _____
- ☐ Other (please specify) _____

☐ Medical Record Abstract (*e.g. Discharge Summary, History & Physical, Operative, Pathology, and Test Reports)*

AUTHORIZATION FOR RELEASE OF SPECIFICALLY

PROTECTED OR PRIVILEGED HEALTH INFORMATION

I request the release of the specific categories of information that I have *INITIALED* below:

_____ HIV test results **(**PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S): _____

_____ Genetic test results (excludes therapeutic genetic tests) **(SPECIFY TYPE OF TEST)** _____

_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

Confidential Details of:
_____ Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling
_____ Sexually Transmitted Diseases

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management, or the Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released per this authorization, if redisclosed by the recipient, is no longer protected by Dana-Farber Cancer Institute.
- I understand that this authorization will automatically expire in 6 months unless otherwise specified _____.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____

Relationship of representative to patient: _____