



Mail or Fax to:

**Partners Release of Information**  
121 Inner Belt Rd.  
Somerville, MA, 02143  
Phone #: 617-726-2361  
Fax #: 617-726-3661

**AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION**

Please print all information clearly in order to process your request in a timely manner.

For copies of radiology images or films, contact 617-952-6249 / Fax 617-952-5942

**A. PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PATIENT DATE OF BIRTH: \_\_\_\_\_

PATIENT MEDICAL RECORD # \_\_\_\_\_

PATIENT ADDRESS: STREET: \_\_\_\_\_ APT. #: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE CONTACT #: DAY: ( ) \_\_\_\_\_ EVENING: ( ) \_\_\_\_\_

**B. PERMISSION TO SHARE:** I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

<p><b>FROM: (e.g. hospital, clinic, or provider name):</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Telephone Number: _____</p> <p><b>PURPOSE:</b> (check the appropriate box)</p> <p><input type="checkbox"/> Medical Care      <input type="checkbox"/> Personal*</p> <p><input type="checkbox"/> Insurance*      <input type="checkbox"/> School</p> <p><input type="checkbox"/> Legal Matter*      <input type="checkbox"/> Other (please specify)* _____</p> <p>* Copying fees may apply</p>	<p><b>TO: (e.g. to whom you would like the information sent):</b></p> <p><input type="checkbox"/> Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent:</p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Telephone Number: _____</p> <p><b>SEND BY:</b></p> <p><input type="checkbox"/> Partners Patient Gateway (if available)</p> <p><input type="checkbox"/> Secure Email (provide email address below) Patient Email Address: _____</p> <p><input type="checkbox"/> Paper Copy via Mail</p> <p><input type="checkbox"/> Fax (provide fax number): _____</p>
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**C. INFORMATION TO BE RELEASED** (Please check all that apply, and specify dates):

<input type="checkbox"/> Medical Record Abstract/dates _____ <i>(e.g. History &amp; Physical, Operative Report, Consults, Test Reports, Discharge Summary)</i>	<input type="checkbox"/> Radiation Reports/dates _____
<input type="checkbox"/> Clinic Visit Notes/dates _____	<input type="checkbox"/> Radiology Reports/dates _____
<input type="checkbox"/> Discharge Summary/dates _____	<input type="checkbox"/> Photographs/dates (costs may apply) _____
<input type="checkbox"/> Lab Reports/dates _____	<input type="checkbox"/> Billing Records/dates _____
<input type="checkbox"/> Operative Reports/dates _____	<input type="checkbox"/> Other <i>(please specify below and include dates)</i> _____
<input type="checkbox"/> Pathology Reports/dates _____	_____
	_____
	_____

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**D. Please check YES to indicate if you give permission to release the following information if present in your record:**

- Yes **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)  
**SPECIFY DATES** \_\_\_\_\_
- Yes **Genetic Screening test results (SPECIFY TYPE OF TEST)** \_\_\_\_\_
- Yes **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 BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.
- Yes **Other(s):** Please List \_\_\_\_\_
- Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (*I understand that my permission may not be required to release my mental health records for payment purposes*)
- Yes Confidential Communications with a Licensed Social Worker
- Yes Details of Domestic Violence Victims' Counseling
- Yes Details of Sexual Assault Counseling

**E. I understand and agree that:**

- Partners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHS may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - if PHS has already relied upon it (for example, once information is released, it will not be retrieved)
  - if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
- I understand that if Partners maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

➤ **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:** \_\_\_\_\_

For Internal Use Only

Information Released/Reviewed By: \_\_\_\_\_ Date \_\_\_\_\_

Clinic/Office: \_\_\_\_\_

Pick-up Identification:

\_\_\_\_\_ License \_\_\_\_\_ State ID \_\_\_\_\_ Passport \_\_\_\_\_ Other Photo ID \_\_\_\_\_