MITMedical

Medical Record Service
77 Massachusetts Ave., E23-023
Cambridge, MA 02139-4307
Phone: 617-253-4906
Fax: 617-258-0884

Authorization for Release of Protected Health Information (PHI) — Medical Record

Important information about releasing patient medical records

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

State and federal laws recognize the need for written authorization.
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 (the patient or personal representative) state in the authorization to release future records of a specific test, specific clinic appointment, etc.

If the patient is 18 years or <u>older</u>, 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 or legal representative with legal proof must sign the authorization for release of the deceased patient's records.)

If the patient is 18 years or <u>younger</u>, the patient *must* sign the release if:

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

Anyone other than the patient who signs this authorization for release of records must state their relationship to the patient and provide proof of legal authority to release the records.

Please read before completing the form on the next page:

- This form must be completed in its entirety and signed by the patient or personal representative to be a valid authorization. Incorrect or incomplete forms will not be processed.
- The MIT Medical Records Service does not fax records. If you wish to have the information disclosed to you directly, you will be charged a fee. The fee is $0.50 per page for the first 100 pages and $0.25 per page for each page thereafter. The fee may be paid by cash, personal check, money order, Visa or MasterCard.
- There is no fee for records released directly to other healthcare providers.
- When copies of the medical record are requested for parties other than the patient, the recipient of the record will be charged a $15 base fee.
- If you wish to complete this form in person at MIT Medical, make sure to bring two forms of ID. One must be a government ID (driver's license, state ID, or passport). If you have any questions or need more information, please call the Medical Records Correspondence Service at 617-253-4906.
- To obtain a copy of test results, procedure and/or notes that were done at another healthcare organization, please contact that organization directly.

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1. PATIENT INFORMATION

Patient last name _____ First name _____ MI _____ Date of birth _____

Patient former name (if any) _____ MIT ID _____

Patient address _____ Patient e-mail _____
Street City State Zip

Patient home phone _____ Work phone _____ Cell phone _____

2. RECIPIENT AUTHORIZATION

I, _____, do hereby authorize _____ to release a copy of my
Patient name or representative Provider or service (e.g., "MIT Medical")

medical record to the person or facility below. *(Please note: MIT Medical does not fax records. A fee may be required for this release.)*

Name of person or facility to receive medical record _____ Street address _____

City, state, ZIP _____ Phone _____

3. INFORMATION TO BE RELEASED — *Please check all that apply and specify dates. To obtain a copy of a test result, procedure and/or visit note(s) that was done at another health care facility, please contact that facility directly.*

☐ Visit notes: _____ ☐ EKG/echo: _____ ☐ Entire medical record: _____

☐ Immunizations: _____ ☐ Lab reports: _____ ☐ Mammograms: _____

☐ Pathology reports: _____ ☐ Stress tests: _____ ☐ X-ray reports: _____

☐ Other *(be specific; include provider name and date(s) of treatment, if applicable)* _____

4. PURPOSE OF INFORMATION RELEASE

☐ 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. INCLUSION OF PRIVILEGED INFORMATION

- I understand that if my record contains information concerning alcohol or drug abuse/ treatment that is protected by Federal Regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 §70, such information will be included in this disclosure.

If you do **not** wish to have released any of the categories of information described above, please specify: _____

_____

6. 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 the 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.

7. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____ Date _____
Signature

Personal representative, print name: _____
Printed name of personal representative

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing:

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ parent ☐ legal guardian ☐ next of kin of deceased

For MIT Medical use only

Date rcvd: _____ **Rcvd by**_____ **ID provided:** _____ **MRN:** _____

Date released: _____ **Processed by:** _____ ☐ **Sent by mail** ☐ **Picked up in person**