MIT Health

MIT Health
Massachusetts Institute Of Technology
77 Massachusetts Ave, E23
Cambridge, MA 02139

Authorization for Release of Protected Health Information (Medical Record) to MIT Health

1. Patient Information

Printed name _____ **DOB** _____
(first, last, mi)

Patient fomer name (if any) _____ **E-mail address** _____

Patient address _____
(number, street, city, state, zip code)

Patient home phone _____ **Work phone** _____ **Cell phone** _____

2. Information to be Disclosed

I hereby authorize _____ **at** _____
(Provider name) (Provider address)

_____ _____
(city, state, zip code) (telephone number)

To disclose a copy of the following portion(s) of my medical record to MIT Health:

- ☐ Admission notes: _____
- ☐ EKGs/echo: _____
- ☐ Pathology reports: _____
- ☐ Consult report: _____
- ☐ Progress notes: _____
- ☐ Immunizations: _____
- ☐ X-ray reports: _____
- ☐ Emergency service report: _____
- ☐ Office notes: _____
- ☐ Lab reports: _____
- ☐ Hist & Phys: _____
- ☐ Entire medical record: _____
- ☐ Stress tests: _____
- ☐ Mammogram: _____
- ☐ Op report: _____
- ☐ Other: _____

3. Recipient Authorization

To the attention of _____ at MIT Health (check location):

- ☐ 77 Massachusetts Ave., Room E23- _____ Cambridge, MA 01239
- ☐ 244 Wood St., Bldg V-110 Lexington, MA 02421

_____ _____
(telephone number) (fax # for further medical care.)

4. Release of Privileged Information

- ☐ Mental health
- ☐ HIV testing and related information
- ☐ Developmental disabilities
- ☐ Alcoholism
- ☐ Sexually transmitted diseases
- ☐ Substance abuse
- ☐ Abortion
- ☐ Genetic testing
- ☐ Domestic/sexual abuse
- ☐ Other: _____

5. 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 Health 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 MIT Health 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.

6. Signature of Patient or Personal Representative

Patient signature _____ **Date**_____

If personal representative, print name:_____

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

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

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