Beth Israel Lahey Health
Mount Auburn Hospital

Authorization To Use and Disclose Protected Health Information

993

Medical Record # : _____

Patient Name: _____ Date of Birth: _____

Address: Street _____ City: _____ State: _____ Zip: _____

Telephone #'s: _____ Medical Record #: _____

REQUESTED DELIVERY FORMAT *(If left blank, paper records will be mailed to you and you could incur a fee.)*

❑ MyChart ❑ Paper ❑ CD (must be picked up) ❑ Fax

INFORMATION TO BE RELEASED *(Please check all that apply and add approximate date(s) of service)*

❑ Discharge Summary _____ ❑ Emergency Room _____

❑ Operative Note _____ ❑ Laboratory Results _____

❑ Pathology Report _____ ❑ Radiology Reports _____

❑ Medical Record Abstract (Most recent 2 years of History & Physical, Discharge Summary, Emergency Room, Operative Report, All Test Results (including cardiology, laboratory, mammography, pathology, and radiology), and Consults. If the records are for Self, we will provide 5 years of mammography/radiology instead of 2.)

❑ Entire Record (includes everything) ❑ Other: _____

THE PURPOSE FOR THIS REQUEST IS

❑ Patient care ❑ Self ❑ Insurance ❑ Legal

❑ Other (please specify): _____

I, _____ (requester name), do hereby authorize _____ (facility)

to release my protected health information to the following person(s) at the locations listed below:

Name of Recipient: _____

Facility: _____

Address: _____

Telephone #: _____ Fax #: _____

TERM: THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL:

❑ Six months from the date of this authorization ❑ Until the following event occurs: _____

Except for Self purposes, I have initialed my authorization of the specific categories of information below:

_____ Any information about HIV/AIDS status

_____ Any information about genetic testing

_____ Any information related to confidential communications with a psychiatrist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other mental health professional or human services professional

_____ Any information about venereal disease

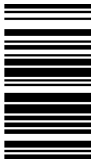
_____ Any information about family planning services

_____ Any information about treatment of substance abuse (alcohol and/or drugs) 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 authorization of the person to whom it pertains is given, or as otherwise permitted by 42 CFR Part 2.)

I understand that once Mount Auburn Hospital discloses my health information to the recipient, the hospital cannot guarantee that the recipient will not re-disclose it to a third party, who may not be required to abide by the state and federal laws governing the use and disclosure of protected health information.

I understand that I may refuse to sign or may revoke this authorization for any reason, and that any refusal will not affect Mount Auburn Hospital's treatment of me, except if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in the authorization, in which case the hospital may refuse to treat me if I do not sign this authorization.

I understand that this authorization will remain in effect until the term of this authorization expires, or I provide a written notice of revocation to the hospital at the address below. The revocation will go into effect immediately upon receipt, except that it will not apply to any action taken by the hospital before receipt of the written notice of revocation.



I understand that any information provided to me pursuant to this request may not include psychotherapy notes, which may only be released with the consent of my therapist. It will not include information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or as may otherwise be limited or restricted by applicable law. If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law. If I am requesting records of a person who has expired, I understand that I must produce papers that show me appointed as executor or administrator of the estate.

I understand that the hospital may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by the Mount Auburn Hospital who did not participate in the hospital's decision to deny my request.

I understand that Mount Auburn Hospital will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request if the information is maintained or accessible on-site at the hospital or within sixty (60) days if the Requested Information is not maintained or accessible on-site. If the hospital is unable to comply with my approved request for information maintained or accessible on-site within thirty (30) days, it may extend the applicable deadline for up to thirty (30) more days by notifying me in writing.

I understand that pursuant to HIPAA 45 CFR, 164.524, Mount Auburn Hospital reserves the right to charge a reasonable cost-based fee for producing and mailing copies of records pursuant to requests to have records mailed to me. For all other release of information requests, the applicable US state statue governing fees for medical records will be applied.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize disclosure of the above protected health information to the persons or agencies listed above.

Signature of Patient: _____ Date:_____ Time: _____

If patient is a minor or incapacitated, signature of legal personal representative:

_____ Date:_____ Time: _____

Send completed form to Mount Auburn Hospital's Health Information Management Department by mail or fax to:

330 Mount Auburn Street, Cambridge, MA 02138 | Fax: 617-499-5178

Telephone: 617-499-5028 | Hours of Operation: Monday - Friday, 8 am - 6 pm