MEDICAL RECORD DEPARTMENT

Emerson Hospital

133 ORNAC, Concord, MA 01742

(978) 287.3907; (978) 287.3652 (fax)

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

REQ#: **MRN:**

Patient Name: _________________________________ DOB: ______________ Telephone**:** ____________________

Address: ____

I hereby authorize Emerson Hospital to release or obtain medical information to/from the individual/organization named below.

Records ***RELEASED*** to:	OR Records ***OBTAINED*** From:
Name:	Name:
Street Address:	Street Address:
City/State/ZIP:	City/State/ZIP:

Treatment Dates: ________________________________ Purpose of Request: ______________________________

Please check information to be released

Discharge Summary	History & Physical	Operative Report	Lab Reports
X-ray Report	Cardiology Report	Rehab Notes	ED Encounter
Full Abstract (H&P, Op Report, Consults, Test Results, Discharge Summary)			
Other:			

In compliance with Massachusetts Statutes which require specific authorization to release otherwise privileged information, please release records pertaining to: (Check all that apply)

- □ Substance Abuse (drug/alcohol) Treatment*
- □ HIV, AIDS or ARC Information**
- □ Information related to sexually transmitted disease(s)
- □ Abortion consents/records or family planning services
- □ Genetic Testing
- □ Sexual Assault Treatment
- □ Domestic Violence Victims Counseling
- □ Social Work Counseling/Therapy
- □ Communications between me, my psychiatrist, psychologist, or other behavioral health professional

*Substance Abuse Treatment records are protected under 42 CFR, Part 2. ** Excludes Emerson Licensed or Referral Physician

I understand that Federal Privacy Laws may no longer protect the information furnished once it has been released.

I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by Emerson Hospital before Emerson Hospital received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Medical Record Department, Emerson Hospital, 133 ORNAC; Concord, MA 01742.
Unless otherwise revoked, this authorization will expire on the following date _______________, or within one year.

<u>I understand that I may be charged a fee for the reproduction of the requested health information. This fee will comply with Massachusetts Law Chapter 111: Section 70 with regard to the inspection and copying of medical records.</u>

Date: _________________ Signature of Patient or Representative: ____

Print Name & Relationship if other than Patient: ____

Date Released: _______________ *Released By:* ___________________

Distribution of copies: Original to medical record; copy to requester.