Health Information Management
133 ORNAC, Concord, MA 01742
(978) 287.3473; (978) 287.3718
Fax (978) 287.3652

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

REQ# ______________ **MR#**______________

Patient Name: _________________________________ DOB: ______________ Telephone: ____________________

Address: ____

I hereby authorize Emerson Hospital to release medical information to the individual/organization named below. Disclosure may be handwritten or electronic.

Furnish to: ____

Address: ____

Treatment Dates: ________________________________ Purpose of Request: ______________________________

Information Requested:

☐ Discharge Summary	☐ History & Physical	☐ Operative Report
☐ Lab Reports	☐ X-ray Report	☐ Cardiology Report
☐ Rehab Notes	☐ Complete Record	☐ Other

1. **If my initials appear here__________,** I specifically authorize release of sensitive information concerning documentation or analysis of any communications between me and my psychiatrist, psychologist, or other behavioral health professional.
2. **If my initials appear here__________,** I specifically authorize release of my HIV, AIDS, or ARC information
3. **If my initials appear here__________,** I specifically authorize release of my records that contain information about venereal disease(s), sexually transmitted disease(s), abortion consents or records, family planning services, and/or genetic testing.
4. **If my initials appear here____________,** I specifically authorize release of my records concerning sexual assault treatment.
5. **If my initials appear here__________**, I specifically authorize release of information about drug or alcohol abuse treatment.

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 Health Information Management Department, Emerson Hospital, 133 ORNAC, Concord, MA 01742.

Unless otherwise revoked this authorization will expire on the following date, event or condition, or within one year:

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I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment.

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.

Date: _________________ **Signature of Patient or Representative:** ____________________________________

If signed by a Personal Representative, please describe authority or relationship: ____

Date Released: ______________ Released By: __________________

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