FENWAY HEALTH
ANSIN BUILDING
1340 Boylston Street
Boston MA 02215
TEL 617.267.0900
WEB fenwayhealth.org

AUTHORIZATION FOR DISCLOSURE OF
Protected Health Information

PATIENT NAME

ADDRESS

PHONE NUMBER | SOCIAL SECURITY NUMBER

DATE OF BIRTH | MAIDEN NAME

I HEREBY AUTHORIZE:

NAME, TITLE

ORGANIZATIONS/DEPARTMENT, ADDRESS, PHONE NUMBER

To release information from my health record to:

NAME, TITLE

ORGANIZATIONS/DEPARTMENT, ADDRESS, PHONE NUMBER

This authorization covers the following records:

❑ All records
❑ My record for treatment of _____ (please specify diagnosis or symptom.)
❑ My record for treatment received during the following time period (please give dates _____ to _____ .

I authorize release of information for the following reason:

❑ Transfer/continuation for medical/mental health care.
❑ Other (please specify) _____

Sensitive Information

The following categories of information will NOT be released from your medical record without your specific authorization. To authorize release, **sign your complete name** next to the categories of information you want released.

Abortion _____ Date of TX
Substance Abuse (alcohol/drugs) _____ Date of TX
Infertility Studies _____ Date of TX
Mental Health _____ Date of TX
Sexually Transmitted Diseases _____ Date of TX
HIV test results or information identifying me as having taken an HIV test _____ Date of TX

This authorization is valid for this request only and will not be honored for any subsequent requests.

This authorization for disclosure (unless expressly revoked earlier) expires after ninety days.

I understand that I may revoke this authorization at any time by making a request in writing to the Privacy Officer of Fenway Health.

I understand that substance abuse records are protected by 42 CFR, Part 2 and may not be disclosed without my specific authorization. Those same federal regulations also protect any substance abuse records from re-disclosure by any third party.

I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me, and do voluntarily consent to disclosure.

Patient's signature or if authorized agent signature, please specify relationship to patient. **Date**

Witnesses signature **Date**