Fenway Health Authorization for Disclosure of Protected Health Information

1.) Patient Information

Patient Name: _____ Name used *(if different):* _____
Date of Birth _____ Address: _____
Phone Number: _____ Email address: _____
Preferred method for Medical Records dept. to contact you (*select one*): ☐ Phone ☐ Email

2.) I give permission to release my protected health information and medical records **FROM**:

Sender/ Facility's name: _____ Phone Number: _____
Address: _____ Fax Number: _____

3.) I give permission to release my protected health information and medical records TO:

Recipient/ Facility's name: _____ Phone Number: _____
Address: _____ Fax Number: _____

4.) Reason for Release: (Select all that apply)

☐ To allow bi-directional communication with service provider (***No records will be sent by medical records; Skip to Section 6)***
☐ Transfer **ALL** care to another provider
☐ Share medical records with another provider
☐ Legal Purposes
☐ Insurance Purposes
☐ Other (*please specify*) _____
_____

5.) The following information is to be disclosed: (Select all that apply)

☐ All Records
☐ Abstract (*includes 2 years of office visits, labs, immunizations, diagnostics & radiology reports)*
☐ Treatment received between dates _____ to _____
☐ Optometry Records
☐ Dental Records
☐ Other (*please specify*) _____
_____

6.) Sensitive Information

*Fenway Health **WILL NOT** disclose the following information without your signed authorization. Please initial next to each type of record you will like to be released:*

☐ I would **not** like sensitive information to be disclosed

- Abortion Care _____
- Alcohol/Substance Use Treatment _____
- Behavioral Health information written by medical provider _____
- Behavioral Health information written by psychiatrist, therapist, mental health clinician or social worker _____

COMPLETE THIS ENTIRE SECTION TO ENSURE NO DELAY IN PROCESSING

- Genetic Testing _____
- HIV/Aids Results or related care _____
- Intimate Partner Violence Counseling _____
- Sexually Transmitted Diseases _____
- Sexual Violence Counseling _____

7.) Signature

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) will remain valid for one year from the date signed below. 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 authorizations. 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.

X _____
Patient's signature or authorized agent's signature (please specify relationship to patient) Date

Mail/Fax to: Fenway Health
Attn: Medical Records Dept
1340 Boylston St. Boston, MA 02215

Phone: 617-927-6191
Fax: 617-425-5713
Email address: medicalrecords@fenwayhealth.org

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