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 PAST NAME(S)

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 symptoms.)
❏ 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
Genetic Testing ________________________ 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 results.

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.

Please fax this form to 617.425.5713 or mail it to Medical Records, Fenway Health, Ansin Building, 1340 Boylston Street, Boston, MA 02215.

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

Witnesses signature **Date**