



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 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 _____ Mental Health _____ Date of TX _____
 Substance Abuse (alcohol/drugs) _____ Date of TX _____ Sexually Transmitted Diseases _____ Date of TX _____
 Infertility Studies _____ 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 _____