**MEDICAL RECORD DEPARTMENT**

Emerson Health

**133 ORNAC, Concord, MA 01742**
**(978) 287.3907; (978) 287.3652 (fax)**

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

**REQ#:** **MRN:**

Patient Name: _____ DOB: _____ Telephone: _____

Address: _____

***I hereby authorize Emerson Hospital to release or obtain medical information to/from the individual/organization named below.***

| **Records *RELEASED* to:** | **OR** | **Records *OBTAINED* From:** |
|---|---|---|
| Name: | | Name: |
| Street Address: | | Street Address: |
| City/State/ZIP: | | City/State/ZIP: |

Treatment Dates: _____ Purpose of Request: _____

**Please check information to be released**

| | | | |
|---|---|---|---|
| Discharge Summary | History & Physical | Operative Report | Lab Reports |
| X-ray Report | Cardiology Report | Rehab Notes | ED Encounter |
| **Full Abstract** (H&P, Op Report, Consults, Test Results, Discharge Summary) | | | |
| **Other:** | | | |

**In compliance with Massachusetts Statutes which require specific authorization to release otherwise privileged information, please release records pertaining to: (Check all that apply)**

| | |
|---|---|
| □ Substance Abuse (drug/alcohol) Treatment* | □ HIV, AIDS or ARC Information** |
| □ Information related to sexually transmitted disease(s) | □ Abortion consents/records or family planning services |
| □ Genetic Testing | □ Sexual Assault Treatment |
| □ Domestic Violence Victims Counseling | □ Social Work Counseling/Therapy |
| □ Communications between me, my psychiatrist, psychologist, or other behavioral health professional | |

*Substance Abuse Treatment records are protected under 42 CFR, Part 2. ** Excludes Emerson Licensed or Referral Physician

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 Medical Record Department, Emerson Hospital, 133 ORNAC; Concord, MA 01742.
Unless otherwise revoked, this authorization will expire on the following date _____, or within one year.

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: _____

Print Name & Relationship if other than Patient: _____

*Date Released:* _____ *Released By:* _____

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