St. Elizabeth's Medical Center
A STEWARD FAMILY HOSPITAL

Authorization to Use and/or Disclose Protected Health Information

☐ Request Completed by _____ (staff initial) Medical Record # _____

I hereby authorize ST. ELIZABETH'S MEDICAL CENTER to use and/or disclose the Protected Health Information specified below from my medical records:

1) PATIENT NAME: (Please Print)_____ Date of Birth:_____

Address:_____
Street City State Zip

Contact Telephone Number(s) _____

2) INFORMATION TO BE DISCLOSED TO:

_____
Person or Facility Name (Please print)

_____
Address (Please print) City State Zip

Fax #_____

Phone #_____

3) TREATMENT DATES: From _____ To _____

4) SPECIFIC RECORDS/REPORTS(S) TO BE RELEASED:

☐Admission History and Physical
☐Discharge Summary
☐Emergency Room
☐ EKG Reports
☐Laboratory Results
☐Imaging Reports (Specify CT, X-Ray, MRI)
☐Pathology Reports
☐Operative Notes
☐Rehab Services (PT, OT, Speech)
☐Other (be specific)
_____
_____

5) RESTRICTED RELEASE: We will **not** disclose the following documentation **unless** you check the box and provide an additional signature:

Release	Signature	Release	Signature
☐ Mental/Behavioral Health & Disability Services Provider Documentation* &		☐ Genetic Testing/Test Results**	
☐ HIV/AIDS Screening Test Results		☐ Alcohol*** and/or ☐ Substance Abuse Treatment***	
☐ Confidential Communications with a Social Worker		☐ Child/Elder Abuse and Neglect & Abuse of an Adult with a Disability	
☐ Rape/Sexual Assault Victim's Counseling		☐ Domestic Violence Victim's Counseling	
☐ Sexually Transmitted Disease			

* This authorization is not valid for use or disclosure of psychotherapy notes
** The term "genetic tests" means only those tests which determine your future chances of developing a disease, not tests done to diagnose a current condition or problem. This includes information related to the testing of embryo's created during IVF.
*** Only applicable to records that are created by an "individual or entity who holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral for treatment." (42 CFR Part 2) Does not include records created or maintained by a general medical facility.

IMPORTANT: THIS AUTHORIZATION IS NOT VALID UNLESS ALL ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

ST. ELIZABETH'S MEDICAL CENTER

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6) EXCLUSION REQUEST:
I request that the following admission(s)/visit(s) be specifically excluded from this request _____ (specify dates of service)

7) PURPOSE OF THE DISCLOSURE:
☐ Medical Care ☐Legal ☐Insurance ☐Personal ☐Other_____

8) TERM: This Authorization will remain in effect for one year or:
☐Until ST. ELIZABETH'S MEDICAL CENTER fulfills this request.
☐From the date of this Authorization until the _____day of_____201_____
☐Until the following event occurs:_____
☐Other: _____

9) REVOCATION: I understand that I may revoke this Authorization at any time by requesting it of ST. ELIZABETH'S MEDICAL CENTER in writing at the address listed below. The revocation will be effective immediately upon ST. ELIZABETH'S MEDICAL CENTER'S receipt of my written notice. I understand that the revocation will not have any effect on any action taken by ST. ELIZABETH'S MEDICAL CENTER reliance on this Authorization before it received my written notice of revocation.

736 Cambridge Street
Attn: Director, Health Information Management
Brighton, MA 02135

10) EFFECT ON TREATMENT: I understand that I may refuse to sign this Authorization for any reason and that such refusal will not affect the commencement, continuation or quality of my treatment at ST. ELIZABETH'S MEDICAL CENTER

11) POTENTIAL FOR REDISCLOSURE: I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by ST. ELIZABETH'S MEDICAL CENTER.

12) ACCESS: I understand that in certain circumstances ST. ELIZABETH'S MEDICAL CENTER has the right to deny me access to all or portions of my Protected Health Information ST. ELIZABETH'S MEDICAL CENTER will notify me in writing of any such denials.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize ST. ELIZABETH'S MEDICAL CENTER to use and/or disclose my health information in the manner described above.

13) _____ _____
Signature of Patient Date

_____
Printed Name of Patient Witness

For Office Use:
☐ I.D Verification_____

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

14) _____ _____
Signature of Personal Representative Date

_____ **15)**_____
Printed name of Patient Representative Relationship to patient or authority to act for patient

Questions about the release should be directed to the St. Elizabeth's Medical Center 617-789-2308

For Office Use:
☐ Copy of this authorization provided to the patient
☐ Copy of this authorization provided to the personal representative

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