HRI HOSPITAL

******* IMPORTANT – BOTH SIDES MUST BE COMPLETED FOR FORM TO BE VALID *******

Mail or fax completed form to:

HRI Hospital, HIM Department, 227 Babcock St., Brookline, MA 02446

Phone: 617-731-3200 Ext. 171 **FAX: 617-232-4914**

AUTHORIZATION TO SHARE PROTECTED OR PRIVILEGED HEALTH INFORMATION

This form demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 1609 and 164 and all federal regulations and interpretive guidelines promulgated there under.

A. PATIENT INFORMATION:

PATIENT NAME: _____ PATIENT DATE OF BIRTH: _____

MAIDEN/PRIOR NAMES: _____

PATIENT ADDRESS: STREET: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE CONTACT #: DAY: ( ) _____ EVENING: ( ) _____

B. PLEASE INITIAL TO INDICATE THAT YOU GIVE PERMISSION TO RELEASE THE FOLLOWING INFORMATION, IF PRESENT IN YOUR RECORD:

____ YES ____ NO **ALCOHOL & DRUG ABUSE RECORDS**. Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2). This consent may be revoked upon oral or written request.

____ YES ____ NO **Details of Mental Health Diagnosis and/or Treatment** provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist or Licensed Mental Health Clinician.

____ YES ____ NO Confidential Communications with a Licensed Social Worker.

____ YES ____ NO Details of HIV (HTLV III) antibody or antigen testing or records containing HIV, HIV virus or any AIDS-related conditions which may be contained in the above request.

____ YES ____ NO Details of Domestic Violence Victims Counseling.

____ YES ____ NO Details of Sexual Assault Counseling.

BACK MUST BE COMPLETED

PATIENT'S NAME:_____ **DOB:**_____

C. INFORMATION TO BE RELEASED: (Please indicate if specific information is needed.)

_____ Discharge Summary _____ Admission Note _____ Psychological Tests
_____ Consultations _____ Lab Work _____ Treatment Plan
_____ Physical Examination _____ Other, please specify: _____

*** **PLEASE NOTE: WE ARE UNABLE TO RELEASE INFORMATION RECEIVED FROM ANOTHER FACILITY.** ***

D. PERMISSION TO SHARE: I give my permission to share my protected health information. Enter the purpose of this request and with whom you would like the information shared.

PURPOSE: (Check the appropriate line)

_____ Medical Care _____ Personal * _____ Insurance _____ School

_____ Legal Matter * _____ Other (please Specify) * _____

* **Copying fees may apply**

E. TO: (Who is to receive the information)

_____ Check here if the records are to be mailed to the patient at the above address (Section A).

Otherwise, complete the information below to indicate where you would like the information released.

NAME: _____ TELEPHONE #: _____

ADDRESS: _____ **FAX** ** #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

** **Information is faxed only for medical care.**

I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of information about my condition to the persons/agencies named above. I understand that this consent is subject to revocation at any time, unless action based on it has already begun. *This authorization automatically* ***expires 6 months from the date below,*** *unless otherwise specified.* My treatment, payment, health plan enrollment or eligibility of benefits will not be affected if I do not sign this form.

PATIENT'S SIGNATURE:_____ **DATE:**_____

PRINT NAME:_____

When the patient is not competent to give consent, the signature of a parent, guardian or other legal representative is required.

SIGNATURE OF LEGAL REPRESENTATIVE:_____ **DATE:**_____

PRINT NAME:_____ **RELATIONSHIP TO PATIENT:**_____