Beth Israel Deaconess Hospital
*Needham*

## AUTHORIZATION FOR THE RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

I hereby authorize members of the Beth Israel Deaconess Hospital – Needham Organized Health Care Arrangement or their agents to use and disclose my individually identifiable health information including release of a copy of my medical record or a specified portion thereof. I understand that the information I authorize an individual or organization to receive may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may inspect or copy the information used, and disclosed. I know that I may revoke this authorization at any time by notifying Beth Israel Deaconess Hospital – Needham Organized Health Care Arrangement and/or my physicians in writing, provided the information has not already been disclosed. I know that this authorization is voluntary. I understand that treatment will not be conditioned on the completion of this authorization. I know that I have the right to request and receive a Beth Israel Deaconess Hospital –Needham *Notice of Privacy Practices*.

**Patient Name:** _____ **Date of Birth:** _____

**Patient Address:** _____ **Home Telephone:** _____

_____ **Alternate Telephone:** _____

_____ **Medical Record Number:** _____

**1. PURPOSE OF RELEASE** *(check appropriate box below)*

☐ Medical ☐ Legal ☐ Insurance ☐ Personal ☐ Other (specify) _____

I authorize Beth Israel Deaconess Hospital – Needham to release of a copy of my medical record or a specified portion thereof to:

☐ **Myself** ☐ **Physician** ☐ **Attorney** ☐ **Other** _____

**Name:** _____ **Fax #** _____

**Address:** _____

**2. DATE(S) OF SERVICE:** _____

**3. INFORMATION TO BE RELEASED** *(check all that apply):*

- ☐ Entire Medical Record
- ☐ Photographs/Videos/Text
- ☐ Operative Reports
- ☐ Discharge Summary
- ☐ X-rays/Scan Reports
- ☐ Medical Records Abstract *(e.g., H&P, Operative Report, Consult Reports, Test Reports, Discharge Summary)*
- ☐ Pathology Reports
- ☐ Radiation Reports (specify) _____
- ☐ Lab Reports
- ☐ Visit Notes (specify office) _____
- ☐ Other (specify) _____

**4. EXPIRATION:** This authorization expires in (please check appropriate box): ☐ 3 months ☐ 6 months ☐ other _____

***(If not specified, all authorizations will expire 12 months from the date this form was signed)***

**I authorize this use, disclosure and release with the understanding that it may include specifically protected or privileged information in one or more of the following categories:**

**a)** information relating to alcohol or drug abuse
**b)** communications between patient and a social worker
**c)** information relating to sexually transmitted diseases
**d)** communications between the patient and psychotherapists (including psychiatrists, licensed psychologists and psychiatric clinical nurse specialists)
**e)** genetic test results (excludes therapeutic tests)
**f)** domestic violence victims' counseling
**g)** sexual assault counseling

**I HAVE PLACED A LINE THROUGH AND INITIALED ANY PORTION OF THE ABOVE THAT LISTS INFORMATION THAT I DO NOT WANT THE BETH ISRAEL DEACONESS HOSPITAL – NEEDHAM ORGANIZED HEALTH CARE ARRANGEMENT TO RELEASE TO THE ABOVE REFERENCED INDIVIDUAL (S) OR ORGANIZATIONS.**

_____ _____

**Signature of Patient or Patient's Representative** **Date**

_____

**Print name & relationship if other than patient**

RIO Authorization 8/2/07

148 Chestnut Street
Needham, MA 02492
www.bidneedham.org

(781) 453-5211
Fax (781) 453-5783

**SPECIAL AUTHORIZATION UNDER MASSACHUSETTS LAW CHAPTER 111 §70F FOR DISCLOSURE OF MEDICAL RECORD INFORMATION INCLUDING THE RESULTS OF HIV ANTIGEN OR ANTIBODY TESTING**

The specific information to be disclosed is any and all medical records including information regarding the history of and/or any record of or results of HIV testing, and/or treatment for AIDS.

**PURPOSE OF RELEASE (check appropriate box below)**:

☐ Medical Care ☐ Insurance ☐ Other (please specify) _____

☐ Legal Matter ☐ Personal

**I understand that the medical record contains information about testing for the HIV antibody or antigen. I do herein expressly and voluntarily consent to disclosure of the medical records information for the purpose or need stated above. I further understand that I am not giving permission for any redisclosure other than specified above. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance thereon.**

I understand that I may inspect or copy the information used, and disclosed. I know that I may revoke this authorization at any time by notifying Beth Israel Deaconess Hospital Organized Health Care Arrangement and/or my physicians in writing, provided the information has not already been disclosed. I know that this authorization is voluntary. I understand that treatment will not be conditioned on the completion of this authorization. I know that I have the right to request and receive a BID-Needham Notice of Privacy Practices.

**Name of Patient:** _____ **Medical Record Number:** _____

**Patient Address:** _____ **Date of Birth:** _____

_____ **Home Telephone:** _____

_____ **Alternate Telephone:** _____

_____ _____

**Signature of Patient or Patient's Representative** **Date**

_____

**Print name & relationship if other than patient**

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