Hebrew Rehabilitation Center
Hebrew SeniorLife

Affiliated with Harvard Medical School

General & Visitor Information — Medical Records

To request your medical record:
Please request in person or send by mail a written request that includes your name, date of birth, social security number, and the approximate date(s) of service. Please state the purpose of the request, what part of the medical record you need. Please indicate who we should send the record to and address, or indicate if you will be picking it up. Please sign and date your request.
***A reasonable copying charge may apply to this request.**

Send medical record requests to:
Hebrew Rehabilitation Center
Health Information Management Systems
1200 Centre Street
Roslindale, MA 02131
Phone: 617-363-8014

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION
❑ RELEASE COPIES OF HEALTH/MEDICAL RECORD
❑ REVIEW HEALTH/MEDICAL RECORD
❑ OBTAIN COPIES OF HEALTH/MEDICAL RECORD FROM ANOTHER FACILITY

PATIENT NAME:_____ PATIENT DATE OF BIRTH:_____

PATIENT MEDICAL RECORD#: _____

PATIENT ADDRESS: STREET:_____APT.#_____

CITY: _____ STATE: _____ ZIP CODE: _____

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

_____ do hereby authorize _____ to release
(Patient Name) (Facility)
my protected health information including copies of my medical record of care received at_____
to the following persons at the locations/facilities listed below, for the purposes described:

Person(s)/Facility/Address (include name and address)		Purpose (Check the appropriate box)
1._____	2._____	❑ Medical Care ❑ Insurance* ❑ Legal Matter* ❑ Personal* ❑ School ❑ Other (please specify)*
_____	_____	
_____	_____	
_____	_____	_____

INFORMATION TO BE RELEASED (Please check all that apply and specify dates):
- ❑ Discharge Summary_____
- ❑ Lab Reports_____
- ❑ Clinical visit notes:_____
- ❑ PT/OT/SP notes:_____
- ❑ Medical Record Abstract (e.g. History & Physical, Consult, Progress Notes, Test Reports, Discharge Summary)
  _____

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

I request the release of the specific categories of information that I have INITIALED below:

❑ **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.) **SPECIFY DATES**_____

❑ **Genetic Screening test results** (SPECIFY TYPE OF TEST)_____ _____

❑ **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INOFMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

❑ **Other(s): Please List** _____

Confidential Details of:

❑ Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
❑ Social Work Counseling/Therapy
❑ Domestic Violence Victims' Counseling
❑ Sexual Assault Counseling

I understand that, I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management Systems. Authorization may be withdrawn except for the following:

- To the extent that action has been taken in reliance on this authorization
- If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy,

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Hebrew Rehabilitation Center.

I understand that this authorization will automatically expire in 6 months unless otherwise specified.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____

Print Name: _____

Signature of Legal Representative: _____**Date:** _____

Print Name:_____ **Relationship to patient** _____