

## 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)	(Check the appropriate box)	Purpose
1. _____ 2. _____	<input type="checkbox"/>	Medical Care
_____	<input type="checkbox"/>	Insurance*
_____	<input type="checkbox"/>	Legal Matter*
_____	<input type="checkbox"/>	Personal*
_____	<input type="checkbox"/>	School
_____	<input type="checkbox"/>	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 INFORMATION 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** \_\_\_\_\_