



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.

Send medical record requests to:

Hebrew Rehabilitation Center
Health Information Management Systems
1200 Centre Street
Boston, MA 02131
Phone: (617)363-8396



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: () _____

I, _____ 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. _____ _____ _____ _____
	<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal Matter* <input type="checkbox"/> Personal* <input type="checkbox"/> Other(please specify)

*Please refer to the HSL Privacy Notice for information on copying fees that may be associated with this request.

INFORMATION TO BE RELEASED (Please check all that apply and specify dates):

- Discharge Summary: _____ Clinic visit notes: _____
- Lab Reports: _____ PT/OT/SP notes: _____
- Medical Record Abstract (e.g. History & Physical, Consult, Progress Notes, Test Reports, Discharge Summary)

This authorization will expire on the 180th day of the signing or as otherwise specified

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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 redisclosed 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** _____

