HARVARD MEDICAL SCHOOL
AFFILIATE

HIPAA Compliant Authorization for Release of Information

Please use this form to authorize Hebrew Seniorlife (HSL) to obtain and/or share health care information to a specific person or facility, when that release is not otherwise allowed by law. This form should be completed by the individual (or legal representative) whose information is being requested or shared.

Patient/Resident Name: ______________________ Patient/Resident Date of Birth: __________

Patient/Resident address: ______________________________________
(Street, City/Town & State)

Telephone Contact Number: ______________________________________

Alternate Phone Number: ______________________________________

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

❑ I give my permission for HSL *to share* my protected health information with the person, agency or facility named below.

❑ I give permission for HSL *to obtain* my protected health information from the person, agency or facility named directed below.

Person(s)/Facility/Address
(include name and address)

1. ______________________

2. ______________________

Purpose
(Check the Appropriate box)

- ❑ Medical Care
- ❑ Insurance*
- ❑ Legal Matter*
- ❑ Personal*
- ❑ School
- ❑ Research
- ❑ Other (please specify)

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** A reasonable copy fee will apply*

I give my permission for the following information to be shared. Please be as specific as possible. Check all that apply and specify dates.

- ❑ History and Physical/Dates ______________________
- ❑ Discharge Summary/Dates ______________________
- ❑ Lab Reports/Dates ______________________
- ❑ Clinic Visit Notes/Dates ______________________
- ❑ PT/OT/SP Notes/Dates ______________________
- ❑ Radiology Reports/ Dates ______________________
- ❑ Billing Records/Dates ______________________
- ❑ Progress Notes/Dates ______________________
- ❑ Other (please specify)/Dates ______________________

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

I *give my permission* to share the specific categories of information that I have INITIALED below:

❑ **HIV test results** as required by M.G.L. c. 111, §70F (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST) **SPECIFY DATES** ____

❑ **Genetic Screening test results** as specified by M.G.L. c. 111, §70G (SPECIFY TYPE OF TEST)

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❑ **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 in reliance on this authorization, if re-disclosed by the recipient, is no longer protected by HSL.

This authorization will expire (specify a date, time period or an event) __________________or, if nothing is specified, it will expire in one (1) year.

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/Resident Signature: ______________________________ Date: ______________

Print Name: ______________________________

Signature of Patient/Resident's Legal Representative: ______________________________ Date: ______________

Print Name: ______________________________

Legal Representative's Authority:

❑ **Activated** Health Care Proxy
❑ Power of Attorney with health care decision authority
❑ Guardian
❑ Other. Please specify______________________________

Completed forms may be returned to the individual that provide you the form, or dropped off in-person, or mailed to one of the following locations:

Roslindale Location:

Health Information Management Systems
1200 Centre Street
Boston, MA 02131

617-363-8014

NewBridge Location:

Health Information Management Systems
7000 Great Meadow Road
Dedham, MA 02026

781-234-9683