Beth Israel Lahey Health
Beth Israel Deaconess Needham

MMROI

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: _____ **Phone #** _____

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. FORMAT:

In what format do you want the information? ☐ Paper ☐ Fax ☐ Other _____

5. 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) Psychiatric Health – mental health information, 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

148 Chestnut Street
Needham, MA 02492
www.bidneedham.org
(781) 453-5211

HEALTH & INFORMATION MGMT
Fax (781) 453-5783
RADIOLOGY
Fax (781) 453-5789

MMROI

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

AUTHORIZATION FOR THE RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

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

RIO Authorization 8/2/07
NMR6563 Rev 5/21

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