

**AUTHORIZATION FOR THE RELEASE OF PROTECTED OR PRIVILEGED INFORMATION**

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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):**

<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Photographs/Videos/Text	<input type="checkbox"/> Radiation Reports (specify) _____
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Visit Notes (specify office) _____
<input type="checkbox"/> X-rays/Scan Reports	<input type="checkbox"/> Other (specify) _____
_____	
Medical Records Abstract (e.g., H&P, Operative Report, Consult Reports, Test Reports, Discharge Summary)	

**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	e) genetic test results (excludes therapeutic tests)
b) communications between patient and a social worker	f) domestic violence victims' counseling
c) information relating to sexually transmitted diseases	g) sexual assault counseling
d) Psychiatric Health – mental health information, communications between the patient and psychotherapists (including psychiatrists, licensed psychologists and psychiatric clinical nurse specialists)	

**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 &amp; relationship if other than patient

PATIENT'S NAME \_\_\_\_\_



MED. REC. # \_\_\_\_\_

DOB \_\_\_\_\_

*Patient Identification*

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**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 12/25