



**AUTHORIZATION TO DISCLOSE  
PROTECTED HEALTH INFORMATION**

**Dear Patient:**

Please complete this form and return it to: Tufts Medical Center, MEDICAL RECORDS DEPARTMENT  
Box 999, 800 Washington Street Boston, MA 02111 to use or disclose your protected health information as  
described below.

• **Patient Information:**

Medical Record # \_\_\_\_\_  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Area Code/Telephone #: \_\_\_\_\_ Alternate #: \_\_\_\_\_

• **Purpose of the Requested Use or Disclosure:**

Medical Treatment or Transfer: \_\_\_\_\_ Legal: \_\_\_\_\_ Insurance: \_\_\_\_\_  
Personal: \_\_\_\_\_ Other (please specify): \_\_\_\_\_

• **Specific Description of Information (must include date(s)):**

Date(s) of Treatment: \_\_\_\_\_  
\_\_\_\_ ER Record  
\_\_\_\_ Discharge Summary \_\_\_\_\_ Pathology Reports  
\_\_\_\_ Operative Report \_\_\_\_\_ Lab Reports  
\_\_\_\_ Clinic Visit Note \_\_\_\_\_ X-Ray/MRI/Cat Scan Reports  
\_\_\_\_ Complete Record \_\_\_\_\_ Therapy (Physical/Occupational)  
\_\_\_\_ Abstract of Record: (e.g. History & Physical, Operative & Discharge Reports, Consults, Lab Reports,  
ER Reports – specify elements to be released) \_\_\_\_\_  
\_\_\_\_ Other: (please specify) \_\_\_\_\_

• **Release of Specifically Protected Health Information**

If the information described above includes information in any category below, *I specifically authorize the use  
or disclosure of such information. Please indicate the specific information to be used or disclosed and sign  
where indicated:*

\_\_\_\_ **HIV/AIDS testing/test results** (patient authorization required for each release request) *Specify date:*  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Legal Representative Date  
Relationship to Patient or Authority to Act on Patients' behalf: \_\_\_\_\_

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\_\_\_ **Genetic testing/test results** *Specify date and type of test:* \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Legal Representative Date  
Relationship to Patient or Authority to Act on Patients' behalf: \_\_\_\_\_  
**(CONTINUED ON BACK)**

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**Information identified in any category below:**

\_\_\_ Alcohol and drug abuse records *Specify dates:* \_\_\_\_\_  
\_\_\_ Mental health treatment/psychotherapy  
\_\_\_ Sexual assault counseling  
\_\_\_ Social service counseling/therapy  
\_\_\_ Venereal diseases/sexually-transmitted diseases

\_\_\_\_\_  
Signature of Patient/Legal Representative Date  
Relationship to Patient or Authority to Act on Patients' behalf: \_\_\_\_\_

- **To Whom Information Will Be Disclosed.** I authorize Tufts Medical Center to disclose copies of my protected health information described above to: *(complete name and mailing address)*

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Attention: \_\_\_\_\_

- **Expiration.** This authorization will expire automatically in 6 months or on the following date or event that relates to me or the purpose of the use or disclosure: \_\_\_\_\_

- **Specific Understandings**

I understand that I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do it won't have any affect on actions taken by Tufts Medical Center before they received the revocation.

I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it.

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

*I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.*

\_\_\_\_\_  
Signature of Patient/Legal Representative Date  
Relationship to Patient or Authority to Act on Patient's Behalf: \_\_\_\_\_