



**AUTHORIZATION TO DISCLOSE
PROTECTED HEALTH INFORMATION**

Dear Patient:

Please complete this form and return it to: Tufts-New England Medical Center, MEDICAL RECORDS DEPARTMENT Box 999, 750 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: _____

____ **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)

