WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

SCAN TO: Patient / Verbal Communication Authorization

PRINT

Patient Identification Area

PERMISSION FOR HEALTH CARE PROVIDERS TO DISCUSS MY HEALTH CARE WITH FAMILY MEMBERS AND FRIENDS

Patient Name: _____ **Date of Birth:** _____ **MRN:** _____

I hereby authorize_____ **permission to discuss** my health information with the following person(s):
NOTE: This permission does not authorize these individuals to make health care decisions on my behalf or request copies of my medical records.

Name: _____

Address: _____

_____

_____

Phone: _____

Name: _____

Address: _____

_____

_____

Phone: _____

Privileged Health Information. Please check the box below to indicate that we may discuss the information below with the individuals above (if in your medical record)

- ❑ **HIV Information**. To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. Ch. 111 §70f.
- ❑ **Genetic Screening** test results
- ❑ **Substance Use Disorder**. To the extent that my medical record contains information regarding substance use disorder treatment that is protected by Federal Regulation 42 CFR, Part 2. (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.) This consent may be revoked upon oral or written request.
- ❑ **Mental Health Information**. I authorize discussion of such information, including details of mental health diagnosis, and/or treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC).
- ❑ Confidential Communications with a Licensed Social Worker
- ❑ Details of Domestic Violence / Intimate Partner Abuse Counseling
- ❑ Details of Sexual Assault Counseling

I understand that:

- I may withdraw my permission to discuss my information at any time through written request to the Department or Practice where I originally submitted it to except to the extent of actions already taken in reliance upon it. Removal of permission to discuss will prevent any future communication from taking place.
- Mass General Brigham cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Mass General Brigham may or may not protect this information once it has been released to the recipient.
- This authorization remains valid until revoked by me or as otherwise specified: _____

Patient or Patient Representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do *not* sign a blank form. If Substance Use Disorder information is being disclosed and the patient is a minor, their authorization is required in addition to the parent or legal guardian, if applicable.

_____	_____	_____
Signature of Patient (if 18 or older); *or* Parent (if patient is under 18); *or* Legal Guardian; or Health Care Agent *(circle one)*	Printed Name of Patient *or* Authorized Individual	Date