PRINT

WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

REQUEST FOR INFORMATION FROM AN OUTSIDE HEALTH CARE ORGANIZATION

Please print all information clearly in order to submit your request in a timely manner.

A. PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** _____

ADDRESS: STREET: _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PREFERRED PHONE #: **(** **)** _____

B. PERMISSION TO SHARE: I give my permission to share my protected health information.

RECORDS FROM: (e.g. hospital, clinic, or provider)

Name of Site Location: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

PURPOSE: (check the appropriate box)

- ❑ Medical Care
- ❑ Insurance
- ❑ Legal
- ❑ Personal
- ❑ School

Other (please specify) _____

_____

SEND RECORDS TO: (specify clinic or department at Mass General Brigham)

Name: _____

Address: _____

_____

Telephone Number: _____

SEND BY:

- ❑ Fax (provide fax number): _____
- ❑ Paper Copy via Mail
- ❑ Secure Email _____

C. INFORMATION TO BE RELEASED (Please check all that apply and **MUST** specify date(s))

- ❑ Date(s) of Medical Record Abstract _____ (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ❑ Date(s) of Clinic Visit Notes _____
- ❑ Date(s) of Lab Reports _____
- ❑ Date(s) of Operative Reports _____
- ❑ Date(s) of Pathology Reports _____
- ❑ Date(s) of Radiation Reports _____
- ❑ Date(s) of Radiology Reports _____
- ❑ Date(s) of Photographs _____
- ❑ Other (please specify below and include dates)

_____

_____

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D. SPECIAL PERMISSION

Please check YES to indicate if you give permission for us to receive the following information if present in your record:

- ❑ Yes HIV test results (Patient authorization required for each release request.)
  Specify dates _____
- ❑ Yes Genetic Screening test results
  Specify type of test _____
- ❑ Yes Substance Abuse Disorder Treatment Records Protected by Federal Confidentiality Rules 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.
- ❑ Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)
- ❑ Yes Confidential Communications with a Licensed Social Worker
- ❑ Yes Details of Domestic Violence/ Intimate Partner Abuse Counseling
- ❑ Yes Details of Sexual Assault Counseling

E. I UNDERSTAND AND AGREE THAT:

- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except if Mass General Brigham has already received the information
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
  _____
- My questions about this authorization form have been answered

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **Print Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____