DANA-FARBER
CANCER INSTITUTE

☐ DFCI
☐ DFCI NHOH
☐ DF/BWCC FH
☐ DF/BWCC MRMC

HEALTH INFORMATION SERVICES

Authorization for Release of Protected Health Information

_____**REQUEST COPIES OF MEDICAL RECORD** _____ **REVIEW MEDICAL RECORD**

MEDICAL RECORD # _____ **DATE OF BIRTH**_____

Patient Name: _____
(Last) (First) (M.I.)

Patient Address: _____

_____

_____

Patient Telephone (for contact): ( ) _____work/home/cell

I, _____, do hereby authorize Dana-Farber Cancer Institute to release my protected health information, including copies of my medical record of care received at (BWH) (Children') (choose one/both if applicable)_____ to the following person(s) at the location/facility listed below for the purpose(s) as indicated:

Person/Facility/Address	Purpose *(check the appropriate box)**
_____ (name)	☐ Medical Care
_____ (street address)	☐ Legal Matter*
_____ (city, state, zip code)	☐ Insurance * ☐ Personal * ☐ Other (please specify)* _____

***Please refer to the Dana-Farber Cancer Institute Policy for information on copying fees that may be associated with this request.**

PROTECTED HEALTH INFORMATION TO BE RELEASED *(Please check the appropriate box(es) and provide dates):*

☐ Clinic visit notes (dates) _____
☐ Operative reports (dates) _____
☐ Discharge summary (dates)_____
☐ X-rays/Scan reports (dates) _____
☐ Films or ☐ Report
☐ Pathology reports (dates) _____
☐ Radiation report (dates) _____
☐ Lab reports (dates)_____
☐ Other *(please specify)* _____

☐ Medical Record Abstract *(e.g. Discharge Summary, History & Physical, Operative, Pathology, and Test Reports)*
_____
_____

Authorization for Release of Specifically Protected Information

I request the release of the specific categories of information that I have *INITIALED* below:

_____ HIV test results **(**PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S): _____

_____Genetic test results (excludes therapeutic genetic tests) **(SPECIFY TYPE OF TEST)** _____

_____ Alcohol and Drug Abuse 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 OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

Confidential Details of:
_____ Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling
_____ Sexually Transmitted Diseases

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management, or the Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released per this authorization, if re-disclosed by the recipient, is no longer protected by Dana-Farber Cancer Institute.
- I understand that this authorization will automatically expire in 90 days from the date below, unless otherwise specified. _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

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: _____

HIS Use Only

Date___/___/_____ Time of Request: _____ ID Verified: Y / N # Pages Given to Patient_____

Dates of Requested Information___/____/____ to ___/____/____ Initials: _____