

FRANCISCAN HOSPITAL for CHILDREN
30 Warren Street, Brighton, MA 02135
(617) 254-3800 x 1890 Medical Record Department

MR # _____

AUTHORIZATION to OBTAIN/RELEASE MEDICAL RECORD INFORMATION

Patient: _____ Date of Birth: _____

Patient's Address: _____

I hereby authorize: Franciscan Hospital for Children to: OBTAIN FROM _____ and/or RELEASE TO (please check)

Facility/School: _____ Other: _____

Address: _____ Address: _____

Attention: _____ Attention: _____

Dates of Service/Treatment: _____

Please check the appropriate information to be obtained/released: Evaluation Report(s) Outpatient Services
Immunizations Physical Examination Admission Note Discharge Summary Consults Treatment Plans Labs
Education Materials Complete Medical Record Other (please be specific): _____

Purpose of disclosure: Medical Care SPED Education Planning (IEP) Legal Other _____

Authorization Conditions: I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of protected health information which may include **Psychiatric records, Sexually transmitted diseases or Sensitive information**, about my condition and treatment to those persons/agencies named above, provided a release of information is done substantially in accordance with applicable laws.

Initial if you do not consent to the release of psychiatric or sensitive information _____ (initial)

This authorization shall be in effect for 120 days following the date of signature. I understand that this authorization may be revoked at any time by written notice to the facility unless action based on it has already begun. A photocopy of this authorization shall constitute a valid authorization. I understand that the person receiving this information may re-disclose any information used in this authorization and the re-disclosed information is no longer covered by the Privacy Rules.

Signature of Patient (if 18 or older); or Parent (if patient is under 18);
or Legal Guardian; or Health Care Agent (**circle one**)

Signature of Witness

Printed Name of Patient or Personal Representative

Date

Printed Name of Witness

Date

Drug & Alcohol Release of Information.

I authorize disclosure of drug and alcohol information (Drug & Alcohol information is protected by Federal Regulation: 42 CFR Part II.)

Signature of Patient

Signature of Witness

HIV Release of Information. To the extent that my medical record contains information concerning HIV (HTLV-III) antibody and antigen testing that is protected by M.C.L. Ch. 111 70f, I authorize disclosure of such information for the following purpose:

Signature of Patient or Personal Representative

Signature of Witness