

## AUTHORIZATION TO RELEASE PROTECTED OR PRIVILEGED INFORMATION

Please print all information clearly. Fields marked with an asterisk ( \* ) are required.

<b>A. PATIENT INFORMATION</b>	
Patient Name*: _____	Birthdate*: _____ / _____ / _____ <small style="margin-left: 100px;">month      day      year</small>
Medical Record Number (if known): _____	
Address*: Street: _____	Unit Number: _____
City*: _____	State*: _____ Zip Code*: _____
Email: _____	Phone Number: (    ) _____

<b>B. PERMISSION TO SHARE:</b> I give my permission to share my protected health information.	
Enter where you would like information sent from, and to whom you would like the information sent	
<b>FROM:</b> (for example: hospital, clinic or provider name)  Hospital: _____ Practice: _____ Provider Name(s): _____	<b>Reason for Release:</b> <input type="checkbox"/> Patient Request <input type="checkbox"/> Legal <input type="checkbox"/> Continuing Care <input type="checkbox"/> Insurance <input type="checkbox"/> Other ( <i>specify</i> ): _____
<b>TO:</b> (for example to whom you would like the information sent)  Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Phone Number: (    ) _____	<b>Method of Release:</b> <input type="checkbox"/> MyBILH Chart <input type="checkbox"/> Mail <input type="checkbox"/> Pick Up on date: _____ <input type="checkbox"/> Email to: _____ <input type="checkbox"/> Fax to: (    ) _____
	<b>Format Requested:</b> <input type="checkbox"/> Paper <input type="checkbox"/> CD <input type="checkbox"/> Other ( <i>specify</i> ): _____

<b>C. Information to be Released*</b> ( <i>check all that apply</i> ):  <input type="checkbox"/> Abstract (history & physical, operative report, test results, discharge summary) <input type="checkbox"/> Emergency Department / Urgent Care Note <input type="checkbox"/> Operative / Procedure Report <input type="checkbox"/> Office / Clinic Visit Notes <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Imaging Results / <input type="checkbox"/> Images <input type="checkbox"/> Laboratory / Pathology Results <input type="checkbox"/> Billing Record <input type="checkbox"/> Other: _____	Date(s) / Date Range*  _____ _____ _____ _____ _____ _____ _____ _____
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**D. Privileged or Specifically Protected Information:** if present in the record, the following types of information will only be release if you check to authorize and **initial** where indicated.

<input type="checkbox"/> Alcohol or Drug Use Treatment	<input type="checkbox"/> HIV / AIDS Diagnosis and/or Treatment
<input type="checkbox"/> Sexually Transmitted Diseases	I give permission to release ( <i>initial</i> ): _____
<input type="checkbox"/> Domestic Violence Victim's Counseling	<input type="checkbox"/> Genetics Testing
<input type="checkbox"/> Sexual Assault Victim's Counseling	I give permission to release ( <i>initial</i> ): _____
<input type="checkbox"/> Communication between Patient and Social Worker	<input type="checkbox"/> Psychiatric Health: mental health information including communication between a patient and a Psychiatrist, Psychologist, and/or Psychiatric Clinical Nurse Specialist
<input type="checkbox"/> Imaging Results / Images	

**E. I understand and agree that:**

- The information which I authorize for release may be re-disclosed by the recipient and no longer protected by federal privacy regulations
- This authorization expires 12 months from the date of signature unless another date or event is specified below:  
\_\_\_\_\_
- I may be charged a fee for copies, summary or media such as a CD
- Signing the authorization is voluntary
- My treatment will not be conditioned on the completion of this authorization
- I may take back this authorization at any time by providing written notice to the entity I provided it to, as long as the information has not already been released
- A Notice of Privacy Practices is available upon request
- My questions about this authorization form have been answered
- I accept the risk involved in requesting records by email

**F. X** \_\_\_\_\_ **OR**  
 Patient's Signature Print Name

**X** \_\_\_\_\_ **and** \_\_\_\_\_  
 Signature of Legal Representative Print Name Relationship to patient

**Date:** \_\_\_/\_\_\_/\_\_\_ **Time:** \_\_\_:\_\_\_ ○ a.m. ○ p.m.

Please return this request form to Winchester Hospital by mail: Winchester Hospital 41 Highland Ave / Health Information Management Dept/Winchester MA 01890 or email to winhosp\_him@lahey.org or fax to: 978-921-7080

**ADMINISTRATIVE USE ONLY**

- If signed by legal representative, what proof of authority was provided?**  Probate Paperwork (deceased patient)  
 Invoked Health Care Proxy  Guardianship Paperwork  Power of Attorney  Other: \_\_\_\_\_
- Pick up Identification:**  License  Passport  State ID  Other: \_\_\_\_\_
- Identification verified by (*initial*):** \_\_\_\_\_