Fenway Health Authorization of Disclosure for Protected Health Information

Patient Name:_____ Phone Number:_____
Name Used:_____(If different from above)
Date of Birth:_____ **o al e r er:**

Patient Address:_____

I give permission to release my protected health information and medical records

1) From:

_____
Name/Title of Provider

Phone Number: _____
Fax Number: _____
Address: _____
_____

2) To:

_____
Name/Title of Provider

Phone Number: _____
Fax Number: _____
Address: _____
_____

3) I give permission to share my medical records:

☐ Records of (circle selection)

Pap Smear
Mammogram
Colon Cancer Screening
Immunizations
Pathology Reports
ER/Hospital Discharge Reports

☐ Treatment received between these dates:
From_____ To_____

☐ Other:_____

☐ All records

4) Fenway Health will not release these types of health information unless we have your explicit permission.

Please initial next to each type of record to be released

Alcohol or Drug Abuse Treatment _____
Behavior/Mental Health Treatment _____
Psychotherapy Information _____
Genetic Test Information _____
HIV/AIDS Test Results or related care _____
Intimate Partner Violence Counseling _____
Sexually Transmitted Diseases _____
Sexual Violence Counseling _____

5) Reason(s) for release:

☐ To share medical records with another provider
☐ Transfer ALL care away from Fenway Health
☐ To allow ongoing bi-directional communication about this patient's care with an outside provider
☐ Other (please specify):_____

This authorization is valid for this request only and will not be honored for any subsequent requests. This authorization for disclosure (unless expressly revoked earlier) will remain valid for one year from the date signed below. I understand that I may revoke this authorization at any time by making a request in writing to the Privacy Officer of Fenway Health. I understand that substance abuse records are protected by 42 CFR, Part 2 and may not be disclosed without my specific authorizations. Those same federal regulations also protect any substance abuse records from re-disclosure by any third party. I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me, and do voluntarily consent to disclosure.

X_____

Patient's signature, or if authorized agent signature, please specify relationship to patient Date

Mail/Fax to: Fenway Health Att Medical Records; 1340 Boylston St.,
Boston MA 02215 Phone: 617-927-6191 Fax: 617-425-5713