

Important information about releasing patient medical records

MIT Medical recognizes the patient's right to confidentiality of protected health information as set forth in federal and Massachusetts state law. You should be aware of these guidelines when requesting medical records.

State and federal laws recognize the need for written authorization.

All releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information on care provided after the date of the patient's signature, unless you (the patient or personal representative) state in the authorization to release future records of a specific test, specific clinic appointment, etc.

If the patient is 18 years or older, the patient *must* sign the release unless:

1. the patient is incompetent,
2. the patient is disabled and cannot sign the form, or
3. the patient is deceased. (The surviving spouse or legal representative with legal proof must sign the authorization for release of the deceased patient's records.)

If the patient is 18 years or younger, the patient *must* sign the release if:

1. the patient is an MIT student, regardless of age
2. the patient is 14 years or older **and** the records involve treatment for mental illness, alcoholism, drug dependence, or AIDS testing,
or
3. the patient's records for release include an abortion procedure.

Anyone other than the patient who signs this authorization for release of records must state their relationship to the patient and provide proof of legal authority to release the records.

Please read before completing the form on the next page:

- This form must be completed in its entirety and signed by the patient or personal representative to be a valid authorization. Incorrect or incomplete forms will not be processed.
- The MIT Medical Records Service does not fax records. MIT Medical also reserves the right to charge for the copies of the mental health medical records. Contact the Mental Health Service for more information.
- If you wish to complete this form in person at the MIT Mental Health Service, make sure to bring two forms of ID. One must be a government ID (driver's license, state ID, or passport). If you have any questions or need more information, please call the MIT Mental Health Service at 617-253-2916.
- To obtain a copy of test results, procedures and/or notes that were done at another health care organization, please contact that organization directly.



Mental Health Service
 77 Massachusetts Ave., E23-368
 Cambridge, MA 02139-4307
 Phone: 617-253-2916 || Fax: 617-253-0162
 medcor@med.mit.edu

Authorization for Release of Protected Health Information (PHI) — Mental Health Record

1. PATIENT INFORMATION

Patient last name _____ First name _____ MI _____ Date of birth _____
 Patient former name (if any) _____ MIT ID _____
 Patient address _____ Patient e-mail _____
Street City State Zip
 Patient home phone _____ Work phone _____ Cell phone _____

2. RECIPIENT AUTHORIZATION

I, _____, do hereby authorize _____ to release a copy of my
Patient name or representative Provider or service (e.g., "MIT Medical Mental Health Service")
medical record to the person or facility below. *(Please note: MIT Medical does not fax records. A fee may be required for this release.)*
 Name of person or facility to receive medical record _____ Street address _____
 City, state, ZIP _____ Phone _____

3. INFORMATION TO BE RELEASED

Please note that requests for release of psychotherapy notes cannot be combined with any other type of request.

- My entire medical record
- Only those portions pertaining to: _____
(be specific; include provider name and date(s) of treatment, if applicable)

4. PURPOSE OF INFORMATION RELEASE

- Further medical care
- Payment of insurance claim
- Legal investigation
- Applying for insurance
- Vocational rehab, evaluation
- Disability determination
- At the request of the individual
- Other (specify): _____

5. INCLUSION OF PRIVILEGED INFORMATION

- I understand that if my record contains information concerning alcohol or drug abuse/ treatment that is protected by Federal Regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 §70, such information will be included in this disclosure.

If you do **not** wish to have released any of the categories of information described above, please specify: _____

6. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to the MIT Medical Records Service, except to the extent that Medical Records Service has already completed action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the MIT Medical from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

7. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

Signature Date _____

If signed by a personal representative, print name: _____
Printed name of personal representative

If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing:

- Patient is: minor incompetent disabled deceased
 Legal authority: parent legal guardian next of kin of deceased

8. SIGNATURE OF WITNESS (optional):

Signature Date _____

For MIT Medical use only

Date received: _____ ID provided: _____ MRN: _____
 Date released: _____ Processed by: _____ Sent by mail Picked up in person Sent by fax