Authorization to Disclose Health Information for Research

PATIENT INFORMATION

Name | Date of Birth (mm/dd/yyyy) | Phone

Address

HEALTHCARE PROVIDER OR ENTITY TO RELEASE INFORMATION

Name | Phone | Fax

Address | Email

SEND TO:

Name | Phone | Fax

Address | Email

PURPOSE

For Research

RECORDS TO BE DISCLOSED (PLEASE CHECK ONE)

- ☐ All records
- ☐ Records for these dates:
- ☐ Other. Please specify:

RELEASE OF SENSITIVE INFORMATION

Please check YES, NO, or NA as to whether you want your records to include each of the types of sensitive information listed below. You need to mark YES and initial (where indicated) for this information to be released; otherwise, this information will be redacted and not disclosed (as applicable).

YES NO NA

☐ ☐ ☐ HIV Information/Test Results

Specify Test Dates:

I specifically give permission to share my HIV test results and related information as required by Massachusetts state law.

Initial here:

☐ ☐ ☐ Sexually Transmitted Diseases

☐ ☐ ☐ Information related to diagnosis or treament of pregnancy

YES NO NA

☐ ☐ ☐ Genetic Counseling/Screening Test Results. I specifically give permission to share my genetics testing/counseling information as required by Massachusetts state law.

Initial here:

☐ ☐ ☐ Domestic Violence

☐ ☐ ☐ Sexual Assault

☐ ☐ ☐ Human Trafficking

☐ ☐ ☐ Social Work Counseling/Therapy

YES NO NA

☐ ☐ ☐ Substance Use Disorder Patient Records (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.)

☐ ☐ ☐ Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse, Specialist, or Licensed Health Clinician.

DELIVERY OF RECORDS (PLEASE CHECK ONE)

☐ Email ☐ Mail ☐ Fax ☐ Other form. Please specify:

SIGNATURE

I understand that:

1. This Authorization is voluntary. I understand that my healthcare provider will not condition my treatment, enrollment, or eligibility of benefits upon my signing this Authorization. If I do not sign it, my records will not be released as directed in this Authorization.
2. This Authorization will expire on: _____ or 6 months after the date of my signature, whichever occurs first.
3. After signing, I may revoke this Authorization at any time by providing a written notice of revocation to my healthcare provider; however any revocation will not affect disclosures made in reliance on this Authorization before receipt of my written revocation.
4. The information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws (except for Substance Use Disorder Patient Records).

Signature of Individual or Legally Authorized Representative

Date

Print Name

If Legally Authorized Representative, please specify relation to patient