MetroWest Medical Center
Framingham Union Hospital • Leonard Morse Hospital

M-ROIAUTHPHI

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Framingham Union Medical Records: **Phone: 508-383-8162** **Fax: 508-383-1654**
Leonard Morse Medical Records: **Phone: 508-650-7216** **Fax: 508-650-7802**

Name of Patient: _____

Home Address: _____

Home Telephone: _____ **Date of Birth:** _____

By applying a "check" next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the type of highly confidential information, if any such information will be used or disclosed pursuant to the Authorization.

- ❑ Abortion
- ❑ Child Abuse or Neglect
- ❑ Drug and Alcohol Abuse
- ❑ HIV/AIDS Testing or Treatment (regardless of result)
- ❑ Psychiatric Illness
- ❑ Psychotherapy Notes
- ❑ Sexual Assault
- ❑ Venereal Disease
- ❑ Psychiatric Admission Note

Other (Specify)_____

PURPOSE FOR THIS INFORMATION

❑ Continuing Medical Care ❑ Personal Use ❑ Attorney/Legal Case ❑ Pre-employment
❑ Disability/Insurance Application or claim ❑ Other (specify) _____

I authorize MetroWest Medical Center to ❑ **Release To** **and / or** ❑ **Obtain From**

_____
Name of Person / Place / Institution

_____
Street City / Town State Zip Code

_____ _____
Phone Number Fax Number (if applicable)

❑ Abstract	❑ Medication Record	**Diagnostic Testing**
❑ Consult	❑ Operative Report	❑ EEG
❑ Discharge summary	❑ Pathology Report	❑ EKG – Echocardiogram, Holter Monitor
❑ Emergency Dept. Record	❑ Progress Notes (nurses)	❑ Laboratory
❑ Face sheet	❑ Progress Notes (physician)	❑ Mammogram originals (must be returned)
❑ History and Physical	❑ Patient Portal Code	**CD's/Film Copies:**
		❑ X-RAY ❑US ❑CT ❑NM ❑BD ❑MAM
Date(s) of Service: _____	**Date(s) of Service:** _____	**Date(s) of Service:** _____

❑ ***FOR BEHAVIORAL MEDICINE ONLY*** **Authorization for verbal release of information and reciprocal communication between MWMC and the below entities** (list name and relationship of person/persons):

FOR OFFICE USE ONLY

TERM: This Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until MetroWest Medical Center fulfills this request
- ❑ Until the following events occurs:_____
- ❑ Other:_____

(OVER)

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION	

I understand that once **MetroWest Medical Center** discloses my health information to the recipient, **MetroWest Medical Center** cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at **MetroWest Medical Center**; except, however, if my treatment at **MetroWest Medical Center** is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case **MetroWest Medical Center** may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice or revocation to **MetroWest Medical Center's** Health Information Department at the address listed below. The revocation will be effective immediately upon MetroWest Medical Center's receipt of my written notice, except that the revocation will not have any effect on any action taken by MetroWest Medical Center in reliance on this Authorization before it received my written notice of revocation.

I may contact MetroWest Medical Center's Correspondence Unit, c/o Health Information Management Department by mail at 67 Union Street, Natick, MA 01760 or 115 Lincoln Street, Framingham, MA 01701, or by telephone at LMH 508-650-7216 or FUH 508-383-8162.

RISK / WARNING

By accepting the custody of the digital disk/film copies, the patient or designated recipient accepts the risks associated with its loss or theft, in recognition that the data may be readable via readily available computer programs and as such, patient privacy compromise may result.

Further, the patient agrees to hold harmless MetroWest Medical Center, its medical staff members, employees and agents from and against any and all injury or damage that may occur as a result of your (your designee's) custody and/or handling of the data disk/film copies.

What gives you the authority to receive the patient's information?

❑ Written patient authorization (please attach)
❑ You are the patient's parent or guardian (please attach evidence)
❑ You are the patient's health care decision maker (please attach evidence such as a medical power of attorney)
❑ The patient is deceased, and you are the personal representative of the patient's estate (please attach evidence)

Other (please explain):_____

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize MetroWest Medical Center to use or disclose my health information in the manner described above.

_____	_____	_____
Signature of the Patient	*Date*	*Time*

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____	_____	_____	_____
Signature of Personal Representative	*Description of Authority*	*Date*	*Time*

Method of Delivery:

❑ I will pick up the records / films ❑ Please mail the records to me Other:_____

MetroWest Medical Center, in compliance with the General Laws of Massachusetts, abides by the current fees for copying medical records

***For Internal Use Only*:** The identity of the requestor has been validated either with a government issued picture ID, such as a driver's license or passport, or comparison of signatures documented in the PHI records.

_____	_____	_____
Signature of employee validating identity	*Date*	*Time*