Patient Label

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Authorization and request is hereby made to (name of Facility):
MetroWest Medical Center Phone: 508-650-7213 • Fax: 508-383-1654 **Other**______________________________

Select method of delivery:

MAIL:_____ PICK-UP:_____ FAXED:_____ EMAIL_____ ELECTRONIC:_____ PATIENT PORTAL:_____

Name of Patient: ______________________________ Date of Birth: ____________________

Account #: ______________________________ Telephone Number:______________________________

Date(s) of Hospital Service:______________________________

Current Address: ______________________________ Email: ______________________________

PLEASE RELEASE THE FOLLOWING INFORMATION:

- ☐ Admission Face Sheet
- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultation Report
- ☐ Operative Report
- ☐ Emergency Dept Record
- ☐ Physician Orders
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Pathology Reports
- ☐ Lab Results
- ☐ Cardiology Reports
- ☐ Respiratory Treatment Notes
- ☐ Medication Record
- ☐ Rehab (PT/OT/ST) Record
- ☐ HIV/AIDS Testing, Treatment, Diagnosis
- ☐ Mental Health Information
- ☐ Radiology Film/CD
- ☐ Cardiology Film/CD
- ☐ Billing Records/Financial Information
- ☐ Other, please specify: __________

____

____

MY HIGHLY CONFIDENTIAL INFORMATION:

By checking any of the boxes next to a category of highly confidential information listed below, I specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ Information about mental health or intellectual disabilities
- ☐ Psychotherapy Notes created by a mental health professional
- ☐ Information about HIV/AIDS-related testing (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- ☐ Information about sexually transmitted diseases
- ☐ Information about alcohol or drug abuse treatment program services
- ☐ Information about sexual assault
- ☐ Information about child abuse and neglect

☐ **RECIPIENT: Name of person or class of persons to whom MetroWest Medical Center may disclose my health information:**

____

☐ **Address of the recipient or where my health information should be delivered:**

____

STREET CITY STATE ZIP CODE

TERM: This Authorization will remain in effect (if left blank below, this authorization will remain in effect for 365 days or one year):

- ☐ **From the date of this Authorization until the ______ day of ________________, 20 _____.**
- ☐ **Until MetroWest Medical Center fulfills this request.**
- ☐ **Until the following event occurs:** ______________________________
- ☐ **Other:** ______________________________

PURPOSE: I authorize MetroWest Medical Center to use or disclose my health information (including the highly confidential information (selected above, if any) during the term of this Authorization for the following specific purpose(s): *[Note: "at the request of the Patient" is sufficient if the Patient is initiating this Authorization]:*

- ☐ Disclosure is at my (patient's) request
- ☐ Further Medical Care
- ☐ Disability Determination
- ☐ Government Agency / Police
- ☐ Attorney / Legal Investigation
- ☐ View Medical Records On Site
- ☐ Personal Use
- ☐ Insurance

I understand that MetroWest Medical Center may charge me a per page fee for the copying services necessary to complete my request.

Release of Information - ROI (1)

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Patient Label

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 MetroWest Medical Center may, directly or indirectly, receive remuneration from a third party in connection with the use or 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 of revocation to MetroWest Medical Center Privacy Office, c/o Medical Record Department, 115 Lincoln St. Framingham, MA, 01702 I 67 Union St. Natick, Ma 01760. The revocation will be effective immediately upon MetroWest Medical Center receipt of my written notice, except that the revocation will not have any effect on any action taken by MetroWest Health Network in reliance on this Authorization before it received my written notice of revocation.
By telephone at: 508-650-7213

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, I hereby, knowingly, and voluntarily authorize MetroWest Medical Center to use or disclose my health information in the manner described above.

______________________________ ______________________________
Signature of Patient Date

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

______________________________ ______________ ______________
Signature of Authorized Personal Representative Date Relationship to Patient

Identity of Requestor Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other specify:______________
Verified by:______________________________ Date: ______________

Date Request Fulfilled by: ______________________ By: ______________________________

Method: ☐ Mailed ☐ Picked-Up by Patient ☐ Fed Ex

Records/Information Provided:
☐ Medical Record(s) for Date(s) Requested
☐ Radiology CD
☐ Cardiology CD
☐ Billing Records
☐ Other: ______________________________