Fenway Health Authorization for Disclosure of Protected Health Information

1.) Patient Information

Patient Name: _____ Name used *(if different):* _____
Date of Birth: _____ Address: _____
Phone Number: _____ Email address: _____

2.) I give permission to release my protected health information and medical records FROM:

Sender/ Facility's name: _____ Phone Number: _____
Address: _____ Fax Number: _____

3.) I give permission to release my protected health information and medical records TO:

Recipient/ Facility's name: _____ Phone Number: _____
Address: _____ Fax Number/E-mail: _____

4.) Reason for Release: (SELECT ONE)

☐ **NO RECORDS WILL BE SENT/RECEIVED**
Will ONLY allow bi-directional communication with service providers

OR

☐ Transfer **ALL** care to another provider
☐ Share medical records with another provider
☐ Legal Purposes
☐ Insurance Purposes
☐ Other (Please Specify) _____

5.) The following information is to be disclosed: (SELECT ONE)

☐ All Records
☐ Abstract (*Includes 2 years of office visits, labs, immunizations, diagnostics and radiology reports)*
☐ Treatment received between dates _____ to _____
☐ Optometry Records
☐ Dental Records
☐ Other (*please specify*) _____

6.) Sensitive Information (**COMPLETE THIS ENTIRE SECTION TO ENSURE NO DELAY IN PROCESSING**)

*The following information **WILL NOT** be disclosed without your signed authorization. Please **INITIAL** next to each type of record you would like released:*

Abortion Care	
Genetic Testing	
Sexual Violence Counseling	
Intimate Partner Violence Counseling	
Behavioral Health Information written by medical provider	

Behavioral Health Information written by psychiatrist, therapist, mental health clinician or social worker	
Alcohol/Substance Use Treatment	
HIV/AIDS Results or Related Care	
Sexually Transmitted Diseases	
I would **NOT** like any sensitive information disclosed	

7.) Legal Notice and Patient Signature

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. By signing below, I affirm that the medical records requested are not being sought for the purpose of investigating, initiating, or imposing civil, criminal, administrative, or professional liability or sanction related to reproductive health care services or gender-affirming care that were lawfully provided in the Commonwealth of Massachusetts (or in another jurisdiction where such care was lawful at the time it was provided).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 authorized agent's signature (please specify relationship to patient) **Today's Date**

Mail/Fax to: Fenway Health
Attn: Medical Records Dept
1340 Boylston St. Boston, MA 02215

Phone: 617-927-6191
Fax: 617-425-5713
Email address: medicalrecords@fenwayhealth.org