Tufts Medical Center

Radiology Department

800 Washington Street, Box #299, Boston, MA 02111
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Information

Medical Record #: ______________________________ (*If known*)

Name: ______________________________ Date of Birth: ______________

Address: ______________________________

Telephone #: ______________________ Alternate #: ______________________

To Whom Information Will Be Disclosed. I authorize Tufts Medical Center to disclose copies of my protected health information described above to: (*complete name and mailing address*) ✓ Check One

______ Physician/Hospital ______ Patient (*____ Pick Up / ____ Mail Out)*

Type of Radiology Imaging Requested: ______________________________

Physician/Hospital Name: ______________________________

Street Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Attention: ______________________ Telephone Number: ______________

Expiration. This authorization will expire automatically in 6 months or on the following date or event that relates to me or the purpose of the use or disclosure: ______________

Specific Understandings. I understand that I may revoke this authorization by notifying the Medical Records Department at any time in writing, but if I do it will not have any affect on actions taken by Tufts Medical Center before they receive the revocation.

I may refuse to sign this authorization. My health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form (except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party). I have a right to receive a copy of this form after I have signed it.

By signing this authorization form, I authorize the use or disclosure of my protected health information as described above. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I have read this form and all of my questions about this form have been answered.
By signing below, I acknowledge that I have read and accept all of the above.

______________________________ ______________ ______________

Signature of Patient/Legal Representative Date Telephone Number

____

Print Name

Relationship to Patient or Authority to Act on Patient's Behalf: ______________________________