TuftsMedicine

☐ 1. **Tufts Medical Center**
Health Information Management Dept
Release of Information
800 Washington Street, Box 999
Boston, MA 02111
Phone: 617-636-6310
Fax: 617-636-4822

☐ 2. **Lowell General Hospital**
Health Information Management Dept
Release of Information
295 Varnum Avenue
Lowell, MA 01854
Phone: 978-937-6327
Fax: 978-937-6869

☐ 3. **Melrose Wakefield Healthcare**
Health Information Management Dept
Release of Information
585 Lebanon Street
Melrose, MA 02176
Phone: 781-979-3215
Fax: 781-979-3217

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____
Last First MI

Address: _____
Street (include Apt#, if applicable)

_____
City State Zip Code

Birth Date: ____ / ____ / ____ Telephone #: _____

Recipient: _____
Name of person or class of persons to whom Tufts Medicine may disclose my health information.

Address: _____

Email Address: _____

TREATMENT DATES:	

INFORMATION TO BE DISCLOSED (check all that apply):

☐ Discharge Summary
☐ Emergency Room
☐ History and Physical
☐ Laboratory Results
☐ Operative/Procedure Report
☐ Radiology Reports
☐ Other (please specify) _____

Please check the format you prefer to receive your medical records:

☐ Paper ☐ Electronic ☐ myTuftsMed

* * **NOTE:** Sending your medical records through email is not a secure method and may put your medical records and personal information at risk.

* * **COPY FEE:** Fees may apply to a request for copies but at no time will exceed a reasonable cost-based fee.

PURPOSE OF DISCLOSURE (PLEASE CHECK ONE):

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Employer ☐ School

☐ Other (specify): _____

TO REQUEST THE RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION, YOU MUST INITIAL BELOW:

TuftsMedicine

_____	Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2.		
_____	HIV Test Results	_____	Genetic Counseling
_____	Sexually Transmitted Disease (STDS)	_____	Domestic Violence
_____	Commonwealth of Massachusetts Sexual Assault	_____	Social Work Counseling/Therapy
_____	Evidence Collection Kit/Sexual Assault Counseling	_____	Psychiatric Records or Information
_____	Professional services of a licensed psychologist		
_____	Psychotherapy Notes (I understand that Psychotherapy Notes are defined as notes recorded in any medium by a mental health professional that documents or analyzes the contents of the conversation during a private, group, joint or family counseling session and that are separate from the rest of the medical record. I also understand that Psychotherapy Notes exclude medication prescriptions and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.)		

FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.

I UNDERSTAND AND AGREE TO THESE CONDITIONS FOR AUTHORIZATION:

Voluntary Disclosure of this information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to obtain treatment.

Revocation I have the right to revoke this authorization at any time and must do so in writing. The revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Request for Review I may inspect or request a copy of the information to be used or disclosed, as provided in 45 C.F.R. 164.524.

Potential for Redisclosure Information disclosed in response to this authorization may be disclosed by the recipient and may not be protected by federal or state law.

HIPAA I understand that HIPAA allows 30 days from receipt for processing. If an extension is needed, I will be notified in writing.

Expiration This authorization will remain in effect for one year unless otherwise specified: _____

Signature of Patient: _____ Date: ____/____/____

Signature of Legal Representative: _____ Date: ____/____/____

Relationship to Patient: _____

Created: 04/2022
Revised: 02/2023; 8/11/2026