Beth Israel Deaconess Hospital - Milton

MRN: ____________________

AUTHORIZATION FOR DISCLOSURE OF PRIVILEGED INFORMATION

1) Patient Name: ______________________________ **Date of Birth:** ____________________

2) Patient Address: ____
Street City/Town State Zip Code

3) I hereby authorize and request Beth Israel Deaconess Hospital - Milton, to provide to:

____
Recipient: Name of person(s) receiving this information

____
Recipient's address

4) A copy of the patient's:

- ☐ Abstract that includes all of the following:
- ☐ Cardiology Reports
- ☐ Consultation
- ☐ Discharge Summary
- ☐ Emergency Dept. Report
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Operative Report
- ☐ Pathology
- ☐ X-Ray, MRI, Scans, X-Ray Reports

☐ Other as specified: ____

Treatment dates: From ____________________ To ____________________

5) Purpose of request is for:
☐ Continuing Care ☐ Personal Use ☐ Insurance ☐ Legal ☐ Other: ____________________

I understand that this Authorization will remain in effect for 6 (six) months or until I provide a written notice of revocation to Beth Israel Deaconess Hospital - Milton except to the extent that action on it has already begun. I hereby, knowingly and voluntarily, authorize Beth Israel Deaconess Hospital - Milton to use or disclose my health information in the manner described above. I understand that once Beth Israel Deaconess Hospital - Milton discloses my information to the Recipient, Beth Israel Deaconess Hospital - Milton cannot guarantee that the Recipient will not redisclose 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.

6) Patient signature: ______________________________ **Date:** ____________________

If Requestor is the patient's representative, complete lines 7 & 8:

7a) Print requestor name: ______________________________ Phone #: ____________________
7b) Requestor signature: ____
8) Requestor relationship to patient: ______________________________

Restricted Information: If applicable, please ***initial*** any areas in the enclosed box:

I am aware the record may contain the following subject matter and that by initialing any of the choices below, I am authorizing the release of that information pursuant to this Authorization:

__________ Alcohol/Drug use or abuse
__________ Documentation on mental health conditions (i.e. anxiety, confusion, depression, etc.) and/or any Social Services communications
__________ History of venereal disease; assault/abuse (sexual, physical, domestic, spousal, elder, child)
__________ Treatment or testing of HIV/AIDS

Witness Signature ______________________________

199 Reedsdale Road Milton, MA 02186 **TEL:** 617 696 4600 **WEB:** www.bidmilton.org