REQUEST & AUTHORIZATION FOR VERBAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

MEDICAL RECORD # _____ **DATE OF BIRTH**_____

Patient Name: _____
(Last) (First) (M.I.)

Patient Address: _____

_____

_____

Patient Telephone (for contact): ( ) _____work/home/cell (circle one)

I, _____, request and do authorize members of my care team to discuss my or my child's protected health information, including information relating to care received at_____ to the following person(s), facilities, and/or agencies at the location/facility listed below for the purpose(s) indicated:

Person/Facility/Address	Person/Facility/Address	Person/Facility/Address
_____ (name)	_____ (name)	_____ (name)
_____ (organization)	_____ (organization)	_____ (organization)
_____ (street address)	_____ (street address)	_____ (street address)
_____ (city, state, zip code)	_____ (city, state, zip code)	_____ (city, state, zip code)
_____ (telephone number)	_____ (telephone number)	_____ (telephone number)

List any limitations requested by the patient:

_____

_____

_____

Purpose *(check the appropriate box)*

- ☐ Medical Care
- ☐ Care Planning/Continuity of Care
- ☐ Resource Planning
- ☐ Education and Support
- ☐ Other (please specify)

_____

_____

Number of discussions authorized:

☐ One
☐ Unlimited

(as necessary to serve purpose)

AUTHORIZATION FOR VERBAL COMMUNICATION OF SPECIFICALLY PROTECTED INFORMATION

I understand that the following types of information will not be discussed unless I have initialed the appropriate line:

I authorize discussion of the specific categories of information that I have *INITIALED* below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)

_____Genetic screening test results **(SPECIFY TYPE OF TEST)** _____

_____ Alcohol and Drug Abuse Treatment Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

Confidential Details of:

_____ Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling
_____ Sexually Transmitted Diseases

I understand that:

- I may withdraw my authorization prior to the disclosure. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released per this authorization, if re-disclosed by the recipient, is no longer protected by Brigham & Women's Hospital.
- I understand that this authorization will automatically expire in 90 days from the date below, or for the duration of treatment, unless specified as follows. _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____

Print Name: _____

Witnessed by: _____ Title: _____ Date: _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____

Relationship of representative to patient: _____