HARVARD UNIVERSITY
Health Services

Health Information Services/Medical Records/Dental Records
75 Mt Auburn St, Cambridge, MA 02138; (617) 495-7911 or (617) 495-2055; Fax (617) 495-8077; email mrecords@huhs.harvard.edu
Radiology Department
75 Mt Auburn St, Cambridge, MA 02138; (617) 496-0699; contact Radiology directly for CDs and films.

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Patient Information:

Patient's Name: _____

Name Used (*if different*): _____

Patient's Telephone #: _____

Patient's HUID Number: _____

Date of Birth: _____

Patient's Address: _____

☐ **I authorize Harvard University Health Services to disclose and/or use the above-named individual's health information as described below :**

Person/Organization receiving the information (name, address, street/city/state/zip): _____

_____

Description of specific information to be disclosed and/or used (include dates of service): _____

_____

Purpose of disclosure: ☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal

☐ Other_____

Disclosure of records in the following categories of highly sensitive information requires your signature. If you wish to authorize the release of records in any of these categories, you must sign the line next to each category you select.

Reproductive Health Services _____

Sexual Assault _____

AIDS/HIV[1] _____

Sexually Transmitted Infection, results and/or treatment _____

Substance Use _____

Genetic Testing _____

Mental Health[2] _____

Photographs _____

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1. I understand that this authorization is voluntary. I need not sign this form in order to ensure treatment, enrollment, or eligibility of health benefits or payment for services rendered to me. I may inspect or copy the information to be used and/or disclosed.
2. I understand that if the organization receiving the information is not a health plan or health care provider, the released information might no longer be protected by Federal privacy laws and might be re-disclosed by the recipient without my authorization.
3. I understand that I have a right to revoke this authorization in writing to the Medical Records Department at any time unless it has already been acted on, and that such revocation will not affect my treatment, enrollment, or eligibility of health benefits or payment for services rendered to me.
4. This authorization is valid for 1 year from the date of signing unless it has been revoked.
5. Insurance applicants: withholding or release of information may be governed by your insurance company's regulations, state law, and/or federal law.
6. I understand that if I have questions about disclosure and/or use by HUHS of my medical information, I may contact the HUHS Privacy Officer at (617) 496-1630.
7. I knowingly and voluntarily authorize HUHS to disclose and/or use the health information specified in the manner described above.

Signature of patient or legal representative: _____

If patient is not signing, indicate representative's authority to act on patient's behalf (e.g., legal guardian):

_____

Today's date: _____

Format of Release: ☐ for pick-up; arrange date w/ Medical Records ☐ mail to patient via USPS

☐ mail to person/organization via USPS ☐ secure email to patient/address Email Address: _____

(1) Includes the fact that an HIV test was ordered, performed, or reported, regardless of whether the results of such tests were positive or negative.

(2) Includes documentation and analysis of any communications between the patient and the patient's psychiatrist, psychologist, social worker, psychiatric nurse, mental health specialist, sexual assault counselor, domestic violence counselor, or other allied mental health or human services professional.