MIT MEDICAL
77 MASSACHUSETTS AVENUE
E23 - 368
CAMBRIDGE, MA 02139

Phone: (617) 253-2916 **Fax: (617) 253-0162**

REQUEST FOR PROTECTED HEALTH INFORMATION TO MIT MENTAL HEALTH SERVICE

Patient Name: _____ Alias _____

Date of Birth: _____ Telephone: _____ e-mail address: _____

Address: _____

I hereby authorized _____ to release a copy of my mental health record to the attention of: _____ at the MIT Mental Health Service for further health care.

Information to be disclosed:

- ☐ Entire Mental Health Record
- ☐ Clinical Summary
- ☐ Other (Please Specify): _____

This notice is valid for a one time release of the mental health and expires in six (6) months from

(date) _____

I understand that I may revoke this authorization by forwarding a notice of cancellation in writing to the Health Information Management/Medical Records Department at any time prior to the execution of this request, and providing that the information has not yet been released. I understand once the information is released, it may be re-disclosed to individuals or organizations not subject to HIPAA and therefore, may no longer be protected by HIPAA.

_____ _____

Patient or Personal Representative Signature Date

_____

Name and relationship of Personal Representative