MIT MEDICAL RECORDS
77 MASSACHUSETTS AVENUE
E23 - 023
CAMBRIDGE, MA 02139

Phone: (617) 253-4906 **Fax: (617) 258-0884**

REQUEST FOR PROTECTED HEALTH INFORMATION TO MIT MEDICAL

Patient Name: _____ Aka: _____

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

Address: _____

I hereby authorized _____ to release a copy of my medical record to

the attention of: _____ at MIT Medical for further medical care.

Information to be disclosed:

Entire Medical Record
History & Physical
Operative Report _____
Radiology Reports: (Please Specify): _____
Clinical Summary
Other (Please Specify): _____
Laboratory Reports: (Please Specify): _____
Consultation Report
Pathology Report
Emergency Services Report

Please give specific authorization for disclosure of records pertaining to:

Mental Health
Alcoholism
Substance abuse
Abortion
AIDS/ARC
HIV Testing and related information
Sexually Transmitted Diseases (STD
Genetic Testing
Domestic/Sexual abuse
Developmental disabilities
Privileged information
Other Specify_____

This notice is valid for a one time release of the medical record 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