HARVARD UNIVERSITY HEALTH SERVICES

Health Information Services/ Medical Records Dental Records	Smith Campus Center 75 Mt. Auburn Street Cambridge, MA 02138	(617) 495-2055	Fax (617) 495-8077	Email: mrecords@huhs.harvard.edu
Radiology	Smith Campus Center 75 Mt. Auburn Street Cambridge, MA 02138	(617) 496-0699		For radiology CD's and films, contact Radiology directly

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

- Patient's HUID Number _____ Date of Birth _____
- Patient's Name: Last _____ First _____ Telephone # _____
- 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 (include ZIP code): _____
=>Description of specific information to be disclosed and/or used (include dates of service): _____

_____

=>Purpose of Disclosure/Use [ ] 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:

- ABORTION _____
- AIDS/HIV [1] _____
- SUBSTANCE ABUSE _____
- MENTAL HEALTH [2] _____
- SEXUAL ASSAULT _____
- SEXUALLY TRANSMITTED DISEASE _____
- GENETIC TESTING _____
- PHOTOGRAPHS _____

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 This authorization is valid for 1 year from the date of signing unless it has been revoked.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.

SIGN HERE: X_____ _____ _____

(Patient/legal representative signature) **(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:

Check One **[ ]** for pickup: arrange date with Medical Records **[ ]** Mail to patient/ addressee via USPS **[ ]** Secure email to patient/ addressee

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.

Edited 11-2023