HARVARD UNIVERSITY HEALTH SERVICES

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO HUHS

- Patient's Name: Last________________ First ________________ Telephone # ________
- Patient's HUID Number ____________________ Date of Birth ______________
- The patient named above (or the patient's legal representative) gives permission to:

____
Name of individual/clinic/hospital, etc.

____
Street City State Zip

TO DISCLOSE TO (please check off correct address):

[ ]	Medical Records Department	75 Mt. Auburn St, Cambridge, MA 02138	(617) 495-2055	Fax (617) 495-8077
[ ]	Mental Health Department	75 Mt. Auburn St, Cambridge, MA 02138	(617) 495-2042	Fax (617) 496-6890
[ ]	Dental Service	114 Mt. Auburn St, Cambridge, MA 02138	(617) 495-2063	Fax (617) 496-0562
[ ]	Law School Health Service	1563 Massachusetts Ave, Cambridge, MA 02138	(617) 495-4414	Fax (617) 495-8090
[ ]	Medical Area Health Service	275 Longwood Ave, Boston, MA 02115	(617) 432-1370	Fax (617) 432-7120

TO THE ATTENTION OF (indicate health care provider to whom information is to be sent): ________________

- Information from my medical record relative to the following (include diagnosis/surgery/dates): ________________

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- Other information which may assist in retrieval of the information (former name/identification number(s): ________________

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- The purpose of the disclosure is: ________________________________

THE FOLLOWING INFORMATION REQUIRES YOUR SPECIFIC SIGNATURE AND WILL BE USED AND/OR DISCLOSED ONLY IF IT IS SIGNED FOR HERE:	
• ABORTION ____________ • AIDS/HIV [1] ____________ • SUBSTANCE ABUSE ____________ • MENTAL HEALTH [2] ____________	• SEXUAL ASSAULT ____________ • SEXUALLY TRANSMITTED DISEASE ____________ • GENETIC TESTING ____________

1. I understand that I may refuse to sign (or revoke) this authorization for any reason and such refusal (or revocation) will not affect the commencement, continuation or quality of medical treatment rendered to me, enrollment or eligibility of health benefits or payment for services rendered to me.
2. I understand that I have the right to revoke this authorization in writing to the releasing facility, unless action on it has already been completed. This authorization is valid for 90 days from the date of signing, unless it has been revoked.
3. I understand that the medical information disclosed pursuant to this authorization might be subject to re-disclosure to an organization that is not a health plan or health care provider, in which case it might no longer be protected by Federal privacy laws and might be re-disclosed by the recipient without my authorization.
4. I knowingly and voluntarily authorize the release of the medical information described about the Harvard University Health Services.

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)**

Patient's address and telephone number: ________________________________

H-100 2/03

(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.