Franciscan
Hospital for Children

FRANCISCAN HOSPITAL for CHILDREN
30 Warren Street, Brighton, MA 02135
(617) 254-3800 x 1890 Medical Record Department

MR #_____

AUTHORIZATION to OBTAIN/RELEASE MEDICAL RECORD INFORMATION

Patient: _____ Date of Birth: _____

Patient's Address: _____

I hereby authorize: Franciscan Hospital for Children to: ❒ OBTAIN FROM and/or ❒ RELEASE TO (please check)

Facility/School: _____ Other: _____

Address: _____Address: _____

Attention: _____Attention: _____

Dates of Service/Treatment:

Please check the appropriate information to be obtained/released: ❒ Evaluation Report(s) ❒ Outpatient Services
❒ Immunizations ❒ Physical Examination ❒ Admission Note ❒ Discharge Summary ❒ Consults ❒ Treatment Plans
❒ Labs ❒ Education Materials ❒ Complete Medical Record ❒ Other (please be specific): _____

Purpose of disclosure: ❒ Medical Care ❒ SPED ❒ Education Planning (IEP) ❒ Legal ❒ Other _____

Authorization Conditions: I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of protected health information which may include Psychiatric records, Sexually transmitted diseases or Sensitive information, about my condition and treatment to those persons/agencies named above, provided a release of information is done substantially in accordance with applicable laws.

Initial if you do not consent to the release of psychiatric or sensitive information_____ (initial)

This authorization shall be in effect for 120 days following the date of signature. I understand that this authorization may be revoked at any time by written notice to the facility unless action based on it has already begun. A photocopy of this authorization shall constitute a valid authorization. I understand that the person receiving this information may re-disclose any information used in this authorization and the redisclosed information is no longer covered by the Privacy Rules.

Signature of Patient (if 18 or older); or Parent (if patient is under 18); _____
or Legal Guardian; or Health Care Agent (circle one)
Printed Name of Patient or Personal Representative _____

Signature of Witness _____ Date _____

Printed Name of Witness _____ Date _____

Drug & Alcohol Release of Information.
I authorize disclosure of drug and alcohol information (Drug & Alcohol information is protected by Federal Regulation: 42 CFR Part II.)

Signature of Patient or Personal Representative _____ Signature of Witness _____

HIV Release of Information. To the extent that my medical record contains information concerning HIV (HTLV-III) antibody and antigen testing that is protected by M.C.L. Ch. 111 70f, I authorize disclosure of such information for the following purpose:

Signature of Patient or Personal Representative _____ Signature of Witness _____