

FRANCISCAN CHILDREN'S
30 Warren Street, Brighton, MA 02135
(617) 254-3800 x 1970
Medical Records Department



INSTRUCTIONS FOR COMPLETING THE RELEASE FORM. PLEASE READ CAREFULLY.

INCOMPLETE RELEASE OF INFORMATION (ROI) FORMS WILL BE RETURNED TO SENDER FOR ADDITIONAL INFORMATION RESULTING IN A DELAY IN PROCESSING YOUR REQUEST.

Section 1

- Provide the patient's legal name, birth date and current address.
- Check off the "RELEASE TO" box to identify that you would like your information sent to:
 - yourself OR
 - Identify where you want the medical record information sent; such as another healthcare provider/PCP/MD, insurance, school, attorney, etc. You must include the person's name that will be receiving the information, and mailing information (a complete street address, city, and zip code).
 - Information will not be sent to a physician practice without primary physician's name.
 - Information will not be sent to insurance without a contact/name
 - Information will not be sent to a school or attorney practice without a contact/ name.
 - Information cannot be processed and the form will be returned to you for completion if all mailing information is not present.
- Check off the "OBTAIN FROM" box to have your information from another provider sent to Franciscan

Section 2

- Indicate the dates of service/treatment for information to be released (you may indicate specific date/dates, a range of dates or year).

Section 3

- Identify the purpose/how the released medical record information will be used.
 - The purpose defines the minimum data set that will be included in the packet sent to you.
 - The data set information is focused on the essential information your health provider, insurance, or school will need and not information irrelevant to the purpose of disclosure.
 - If you wish additional info, check the box and the other info you would like included
 - If you wish the complete record, state that under OTHER and state the purpose (if purpose is not stated ROI is incomplete).

Section 4

- The authorization is in effect for **120 days from the date of your signature.**
- Any authorization older than 120 days will not be considered valid. No Information will be sent.

Section 5

- If your record contains protected/sensitive information check appropriate boxes to identify the information you wish to have included in the release or excluded from the release.
 - If you had an inpatient stay on Unit 1 you must indicate Psychiatric records to obtain the Admission & Discharge summary.
 - When left blank protected/sensitive information will not be included and you may receive no information or incomplete information.

Section 6

- Please sign and date the form and if you are not the patient, check the relationship with the patient.
- If you are not the patient or parent, a copy of guardianship papers/mittimus/health care agent or other legal document giving you such authority for access must be provided or the ROI will not be processed.
- Please print your name.
- Please have a witness sign the form and print their name.

**If you have questions, please contact the Medical Records Department at:
617-254-3800, Ext. 1970 or Fax: 617-779-1269**