Authorization to Disclose Protected Health Information

PATIENT INFORMATION

Name | **Date of Birth (mm/dd/yyyy)** | **Phone Number**

SEND TO:

Sargent Choice Nutrition Center
Boston University College of Health and Rehabilitation Sciences: Sargent College
635 Commonwealth Avenue, 6th Floor
Boston, MA 02215

Phone: 617-353-2721
Fax: 617-358-5460
For secure email: scnc@bu.edu

PURPOSE

To a Health Care provider for my treatment

RECORDS TO BE DISCLOSED (PLEASE CHECK ONE)

- ☐ Recent records including: intake; transfer; medication evaluation; termination; testing report; most recent therapy and medication notes
- ☐ All records
- ☐ Records for these dates
- ☐ Please have my treating provider send a summary of my treatment to the Recipient.
- ☐ Other. Please specify:

RELEASE OF SENSITIVE INFORMATION

If your medical record contains the following types of records, they will be disclosed only if you initial next to each:

- ☐ Information relating to Acquired Immuno-deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken. **Initial**
- ☐ Genetic testing information including test results. **Initial**
- ☐ Information about sexually transmitted diseases **Initial**

DELIVERY OF RECORDS (PLEASE CHECK ONE)

- ☐ Physical copy to be delivered to Recipient by: ☐ Mail ☐ Fax
- ☐ Secure, encrypted email
- ☐ Other form. Please specify:

SIGNATURE

I understand that:

1. This Authorization is voluntary. I understand that my treatment by this health care provider does not depend upon my signing this Authorization. If I do not sign it, my records will not be released as directed in this Authorization.
2. This Authorization will expire on: _____ or 6 months after the date of my signature, whichever occurs first.
3. After signing, I may revoke this Authorization at any time by providing a written notice of revocation to Danielsen Institute administrative staff; however any revocation will not affect disclosures made in reliance on this Authorization before receipt of my written revocation.
4. The information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

Signature of individual or Legally Authorized Representative

Date

If Legally Authorized Representative, please specify relation to patient

FOR OFFICE USE

Date Authorization Received

Received by (name, title)

Patient/Client Medical Record Number

Please check all selections that apply:

- ☐ Patient or patient's friend/family member known to me picked up documents in person
- ☐ If records are picked up in person by someone other than patient, verify identity by picture ID:
  - ☐ Driver's License ☐ State ID ☐ Passport ☐ Other ID: _____
- ☐ If mailing records, verify name and address of recipient
- ☐ If emailing, verify email address. Use encrypted email unless patient has authorized non-secure email in writing
- ☐ If signed by patient's Legally Authorized Representative, verify copy of court appointment or other documentation of representative's authority. Contact Office of the General Counsel or HIPAA Privacy Officer with questions.

Original Authorization:

☐ Keep in individual's record ☐ Copy to accompany release

Name of person fulfilling the request

Date completed