Patient Name ______________________
Date of Birth ______________________

Joslin Clinic

Affiliated with
Beth Israel Deaconess Medical Center

One Joslin Place, Boston, MA 02215
617-732-2400

REQUEST FOR EXTERNAL PROTECTED HEALTH INFORMATION (PHI)

By signing this document, I authorize ______________________ to use or disclose the above named individual's health information as described below.

The type of information to be used or disclosed is as follows (check all appropriate boxes and specify dates).

Please supply date ranges:

☐ Office Notes		☐ Medical record for last 5 years
☐ Eye Records	☐ Eye Photographs	☐ Labs
☐ Other (please define)		

Additionally, I authorize the disclosure of PHI involving the following information if contained in my record:

☐ Alcohol/drug abuse	☐ AIDS/HIV/ARC	☐ Sexually transmitted disease	☐ Sexual assault/abuse
☐ Domestic violence	☐ Communications with mental health, psychiatry, and/or social workers		

The information identified above should be sent to:

Joslin Clinic
ATTN: ______________________ *(recipient's name)*
One Joslin Place
Boston, MA 02215

The PHI is to be disclosed for the purpose of a medical appointment on:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Joslin Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire in ______________________________

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed, with the exception of my authorization for AIDS/HIV/ARC information, which must be renewed for each request.

I understand that once the above information is disclosed, the recipient may redisclose it and the information may not be protected by federal privacy laws and regulations.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

____ ________________________

Signature Date

____

Relationship to patient if signed by legal representative

****

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