Joslin Diabetes Center

One Joslin Place
Boston, MA 02215
Tel: (617) 309-2518

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

This document authorizes Joslin Diabetes Center to use or disclose the following information as described below.

Patient Name: ____

Address: ____

Date of Birth: ______________________________

Medical Record Number: _____________________

Type(s) of information to be released (check all appropriate boxes **and** specify dates).

☐ Office Notes (dates/time frame: __________ to _________)		☐ Medical Records (last 2 years)
☐ Eye Records	☐ Eye Photographs	☐ Medical Records (last 5 years)
☐ Lab Results		
☐ Other (please describe)		

Additionally, I authorize Joslin Diabetes Center to disclose PHI regarding the following information, if contained in my record:

☐ Alcohol or Substance Abuse	☐ HIV/AIDS-related	☐ Sexually Transmitted Disease
☐ Domestic Violence	☐ Mental Health (not including psychotherapy notes)	☐ Sexual Assault/Abuse

The information identified above may be used by or disclosed to the following individual(s) or organization(s):

Name:____

Address:____

Phone:______________________________ Fax:_________________________________

(Use additional sheets of paper if necessary)

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Reason for release of PHI (**<u>*Fee may apply</u>**):

☐ **Legal***	☐ **Personal***	☐ Research
☐ Fundraising	☐ Marketing	☐ Medical Care
☐ **Other* (please describe)**		

This authorization will expire on ______________________________________. If no date is stated, this authorization will expire **[one year]** after the date this form is signed, with the exception of my authorization for HIV/AIDS-related information, which must be renewed for each request.

* * *

I understand that I have the right to inspect or copy the protected health information described by this authorization.

I understand that I have right to revoke this authorization at any time. I also 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 at the address stated below.

I understand that the healthcare services I receive at Joslin Diabetes Center and any payment for such services will not be affected if I refuse to sign this form.

I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal or state privacy laws.

I have read this form and accept all of the above.

____ _________________________
Signature Date

____
Relationship to patient if signed by legal representative

For questions or assistance with this form, please contact:
Shalena Bonnett, Supervisor
Health Information Management
Joslin Diabetes Center
One Joslin Place, Room 101-F
Boston, MA 02215
Phone: (617) 309-2518
Fax: (617) 309-5705