AUTHORIZATION FOR RELEASE OF MEDICAL IMAGES

Revised November 2019

IMAGE SERVICE CENTER

55 Fruit Street–Blake Sub-basement 0029A | Boston, MA 02114 | Telephone: (617) 726-1798 | Fax: (617) 724-0264

Patient Name: _____

Medical Record #: _____ **DOB:** _____

I hereby authorize Massachusetts General Hospital to furnish medical images from my image file including Partners Urgent Care Centers.

By signing below, I consent MGH Imaging to act on behalf of the Partners HealthCare System, Inc. ("Partners") providing me with copies of all images of me in my medical record, with associated reports, taken at any Partners Urgent Care Centers or with the following subset of images of me in my medical record, with associated reports, taken at any Partners Urgent Care Centers. I hereby release Massachusetts General Hospital, its agents and employees from any and all liability that may arise from the release of the requested medical images.

For Release of CDs/DVDs:
Digital images on CD/DVD should not be returned. NOTE: I understand that if there are mammography images on this CD/DVD, they are not intended for finalized interpretation unless viewed by a Radiologist on an FDA approved monitor. If this CD/DVD contains Tomosynthesis images they can only be viewed on a licensed Tomography device.

I understand this policy as it has been explained to me.

I acknowledge receiving _____ CDs/DVDs

Thank you in advance for handling, these images with care.

_____ _____

Date **Patient Signature or Signature of Presenter (if not Patient)**

_____ _____

ISR Initials **Relationship of Presenter**

☐ **Presenter's ID Photocopied**

MGH 1811 MASS GENERAL IMAGING

A FOUNDING MEMBER OF PARTNERS HEALTHCARE

PARTNERS HEALTHCARE

MGH 1811 MASS GENERAL IMAGING

Mail or Fax to:
MGH Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143-4453
Phone: 617 726 2361
FAX: 617 726 3661

For copies of radiology images or films, contact 617-726-1798 / Fax 617-724-0264
http://www.massgeneral.org/imaging/about/order_images_films.aspx

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner.

A. PATIENT INFORMATION

PATIENT NAME: _____ **PATIENT DATE OF BIRTH:** _____

PATIENT MEDICAL RECORD # _____

PATIENT ADDRESS: **STREET:** _____ **APT. #:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE CONTACT #: **DAY: ( )** _____ **EVENING: ( )** _____

B. PERMISSION TO SHARE:

I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

FROM: (e.g. hospital, clinic, or provider name):

Name: _____

Address: _____

_____

Telephone Number: _____

PURPOSE: (check the appropriate box)

- ☐ Medical Care
- ☐ Personal*
- ☐ Insurance*
- ☐ School
- ☐ Legal Matter*
- ☐ Other (please specify)* _____

* Copying fees may apply

TO: (e.g. to whom you would like the information sent):

☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent:

Name: _____

Address: _____

_____

Telephone Number: _____

SEND BY:

- ☐ Partners Patient Gateway (if available)
- ☐ Secure Email (provide email address below)
  Patient Email Address: _____
- ☐ Paper Copy via Mail
- ☐ Fax (provide fax number): _____

C. INFORMATION TO BE RELEASED (Please check all that apply, and specify dates):

- ☐ Medical Record Abstract/dates _____
  (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
- ☐ Clinic Visit Notes/dates _____
- ☐ Discharge Summary/dates _____
- ☐ Lab Reports/dates _____
- ☐ Operative Reports/dates _____
- ☐ Pathology Reports/dates _____
- ☐ Radiation Reports/dates _____
- ☐ Radiology Reports/dates _____
- ☐ Photographs/dates (costs may apply) _____
- ☐ Billing Records/dates _____
- ☐ Other *(please specify below and include dates)* _____

_____

_____

_____

_____

See Page 2 on Reverse

PARTNERS HEALTHCARE

MGH 1811 MASS GENERAL IMAGING

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

D. Please check YES to indicate if you give permission to release the following information if present in your record:

☐ Yes **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATES _____

☐ Yes **Genetic Screening test results (SPECIFY TYPE OF TEST)** _____

☐ Yes **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.) This consent may be revoked upon oral or written request.

☐ Yes **Other(s):** Please List _____

☐ Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) *(I understand that my permission may not be required to release my mental health records for payment purposes)*

☐ Yes Confidential Communications with a Licensed Social Worker

☐ Yes Details of Domestic Violence Victims' Counseling

☐ Yes Details of Sexual Assault Counseling

E. I understand and agree that:

- Partners HealthCare System (PHS) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHS may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
    - if PHS has already relied upon it (for example, once information is released, it will not be retrieved)
    - if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified:
- I understand that if Partners maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

➢ **Patient's Signature:** _____ ➢ **Date:** _____

➢ **Print Name:** _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:** _____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date _____

Clinic/Office: _____

Pick-up Identification:

_____ License _____ State ID _____ Passport _____ Other Photo ID _____