Marino Center
for integrative health

MOUNT AUBURN HOSPITAL

AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION
RECORD RELEASE FROM OUTSIDE ENTITIES

By signing this authorization, I hereby authorize _____
_____
_____
to release health information including copies of my medical records to the following person(s) and/or facility to:

The Marino Center

2500 Massachusetts Avenue

Cambridge, MA 02140

Purpose *(Check the appropriate box and include a short description):*

At the Request of the Individual / Patient: _____
Continuum of Medical Care: _____
Changing Primary Care Provider: _____
Legal Matter: _____
Insurance: _____
Other *(please specify)*: _____

INFORMATION TO BE RELEASED

ENTIRE RECORD

OR

☐ **INDICATE ONLY THOSE RECORDS THAT YOU WANT RELEASED BY CHECKING ALL THAT APPLY WITH THE DATE RANGES NOTED IN THE SPACES PROVIDED:**

Physician Notes: _____ Lab Results: _____
Radiology Report: _____ Operative Report: _____
Pathology Report: _____ Other (specify): _____

I request the release of the specifically protected or privileged categories of information that I have *INITIALED* below:

_____ HIV test results (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S): _____

_____ Alcohol and Drug Abuse Records Protected by Federal confidentiality Rules 42 CFR Part 2 (FEDERAL RULE PROHIBITS ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR Part 2)

_____ Other(s) Please List _____

Confidential Details of:

_____ Psychotherapy notes (notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling, and that are separate from the medical record
_____ Other professional services of a licensed psychologist
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling

Individual or Individual's Personal Representative MUST read and initial the following statements.

1. INITIALS: _____ I understand that the Marino Center will not condition my treatment, (and applicable; payment for my health care, my enrollment in a health plan or eligibility for benefits) on whether I provide authorization for the requested use and disclosure – except in limited circumstances (e.g., if the treatment is research-related or the treatment is necessary for the purpose of creating protected health information for disclosure to a third party such as physical examinations for school, camp, or employment purposes).

2. INITIALS: _____ I understand that I have a right to revoke this authorization at any time. My revocation must be in writing *(insert explanation of how to revoke: e.g., on the form provided to me / in a letter).* I understand that such revocation does not affect any action taken by the Marino Center before the Marino Center received my written notice.

3. INITIALS: _____ I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

4. INITIALS: _____ I understand that I may see a copy of the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it.

5. INITIALS: _____ I understand that this authorization expires on:

   _____ **or** _____.
   (Identify Date (Month, Day, and Year)) (Identify Expiration Event)

6. INITIALS: _____ I understand that this authorization is voluntary and I have the right to refuse to sign this authorization.

Form must be completed before signing

_____ _____
Signature of Individual or Personal Representative of Individual **Date**

Print Name of Individual: _____ **DOB:** _____

Printed Name of Personal Representative: _____

Relationship of Personal Representative to Individual: _____

***YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION ***