BOSTON MEDICAL CENTER

1000175

Authorization for Two-Way Exchange of Information

Patient Name: _____

Date of Birth: _____ MR#: _____

Address: _____
Street

_____
City State Zip

I give permission for disclosure of my individually-identified health information and communication between the individuals listed below.

Name: _____ Name: _____

Boston Medical Center, Boston, MA 02118 Address: _____

Telephone: _____ Telephone: _____

Purpose for the authorization:
☐ **Referral** ☐ **Coordination of care** ☐ **Other** (specify): _____

The information exchange covers the period of my healthcare from:
☐ **Specific date(s):** _____ to _____ **OR** ☐ **All past, present and future encounters/visits**

Information to disclose (check all that apply):
☐ Medical Record abstract (ED, History & Physical, Operative Record, Discharge Summary, Consultations, Lab, Pathology/Radiology reports, Procedure Notes, Problem List and Medications)
☐ Treatment plan
☐ Other (specify): _____

If you wish the following information to be shared, you much check each item of information that may be shared.
☐ Behavioral/Mental Health Communications (psychiatrist; psychologist; clinical nurse specialist; educational, marriage, family, rehabilitation, or mental health counselor)
☐ Rape Victim Counseling ☐ Domestic Violence Counseling ☐ Social Worker Communications ☐ Genetic Testing
☐ **HIV/AIDS** ☐ Sexually Transmitted Diseases ☐ Abortion Consent Form

SUBSTANCE USE DISORDER TREATMENT
☐ All my substance use disorder information, **OR**
☐ Specific information as checked below:
- ☐ Name and other identifying information that discloses that I am or was a patient in substance use disorder treatment
- ☐ Admission date ☐ Assessment results and history ☐ Attendance history
- ☐ Urine or blood test ☐ Discharge date ☐ Summary of treatment plan, progress and compliance
- ☐ Other (describe): _____

By signing this authorization form, I understand that:
- I have the right to withdraw my authorization at any time except to the extent that Boston Medical Center has already acted based on this authorization. To take back this authorization, I must do so in writing and present my written revocation to the Director of Medical Records.
- Authorizing the disclosure of my health information is voluntary.
- I can refuse to sign, and Boston Medical Center will not condition my treatment, payment, health plan enrollment, or eligibility for benefits on my providing authorization for the requested use or disclosure.
- *Substance Abuse Records Protected by Federal Confidentiality Rules 42.C.F.R. Part 2: FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURES OF THIS INFORMATION UNLESS DISCLOSURE IS EXPRESSLY PERMITTED BY WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42.C.F.R. PART 2.*

Date or event on which this authorization will expire: Date: _____ /_____ /20____ **OR** Event: _____

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire **ONE YEAR** from the date signed below.

Sign Name: _____ Print Name: _____ Date: _____ Time: _____
Patient

Sign Name: _____ Print Name: _____ Date: _____ Time: _____
Parent/Guardian/Surrogate (if applicable)

Sign Name: _____ Print Name: _____ Date: _____ Time: _____
Provider/Physician/Witness (as applicable)

I interpreted the provider's explanation. (Interpreter must sign below, if applicable)

Sign Name: _____ Print Name: _____ Date: _____ Time: _____