Beth Israel Deaconess Hospital
*Plymouth*

# AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize Beth Israel Deaconess Hospital-Plymouth ("BID-Plymouth"), 275 Sandwich Street, Plymouth, MA, 02360 to use or disclose the following health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient Name:** _____ **Date of Birth:** _____

   Address: _____
   Street City State Zip

   Phone Number: _____

3. **Information to be disclosed to:** _____
   Name

   Address: _____
   Street City State Zip

4. **Disclose the following information for treatment dates:** _____ to _____:

   ☐ **Abstract (**Includes Discharge Summary, History & Physical, Consults, Operative/Procedure Reports, All Diagnostic Test results, Clinic Notes , Emergency Room Report)

   ☐ Consult ☐ Physical Therapy
   ☐ Discharge Summary ☐ X-Ray ☐ Emergency Report
   ☐ History & Physical ☐ Laboratory ☐ Other (specify) _____
   ☐ Outpatient Reports ☐ Pathology
   ☐ Complete Record (additional time and copying fees may apply)

5. The above information is disclosed for the following purpose: ☐Medical Care ☐Legal ☐Insurance ☐Personal

6. The means of delivery for the above information: ☐In person ☐Mail

7. I understand I may **revoke this authorization** at any time by requesting such of the above-referenced hospital, physician, or facility, in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization **expires** after ninety (90) days from the date I signed it unless otherwise specified.

   _____ _____
   Signature of Patient or Legal Representative Date

   _____ _____
   Printed name of Patient or Legal Representative Relationship to Patient or authority to act for patient **(attach documentation)**

8. I understand that my record may contain information in reference to treatment for substance abuse and/or alcohol abuse, psychiatric treatment, sexually transmitted diseases, social service notes, HIV/AIDS, or other sensitive information. I agree to its release unless otherwise specified (please explain).

   _____ _____
   Signature of Patient or Legal Representative Date

   _____ _____
   Printed name of Patient or Legal Representative Relationship to Patient or authority to act for patient **(attach documentation)**

**Please return this request form in person, by mail or by fax to (508) 830-2378**.

**(Rev. 06/28/16)**