



**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 Reports)
- 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**)