Beth Israel Lahey Health
Beth Israel Deaconess 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:** ____/____/_____ **Phone #:** _____

   Address: _____
   Street City State Zip

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

   Address: _____
   Street City State Zip

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

   ☐ Abstract (i.e. - History & Physical, Operative/Procedure Reports, Clinic Notes, Discharge Summary, Diagnostic Test Results, Emergency Room Reports)
   ☐ Consultations ☐ Diagnostic Imaging ☐ Discharge Summary ☐ Emergency Reports
   ☐ History & Physical ☐ Laboratory Reports ☐ Operative Notes ☐ Outpatient Reports
   ☐ Pathology Reports ☐ Progress Notes ☐ Therapy ☐ X-Ray/X-Ray Reports (specify below)
   ☐ Other (specify) _____ _____

   ☐ Entire Medical 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 of the above information shall be:
   ☐ In person ☐ Mail ☐ Fax to: (___) _____ ☐ E-mail to:_____@_____ ☐ Other_____

7. In what format do you want the information? ☐ Paper ☐ USB ☐CD

8. 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/Authority to Act for patient **(attach documentation)**

9. 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, Genetic Testing 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/Authority to Act for patient **(attach documentation)**

Please return this request form in person, by mail or by fax to (508) 830-2378. **(Rev. 05/05/21)**