Beth Israel Lahey Health
New England Baptist Hospital

125 Parker Hill Avenue
Boston, Massachusetts 02120

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

I authorize the New England Baptist Hospital to use or disclose my health information

To: _____

Address: _____

Specific Information to be Released: _____

_____

For the following specific purpose(s): _____

_____

I understand that this authorization is voluntary and the hospital will not condition treatment on completion of this authorization.
I authorize this use, disclosure and release with the understanding that it may include specifically protected or privileged information in one or more of the following categories: a) information relating to alcohol or drug abuse; b) communications between the patient and a social worker; c) information relating to sexually transmitted diseases; d) communications between the patient and psychotherapists (including psychiatrists, licensed psychologists).

I have placed a line through and initialed any portion of the paragraph above that lists information which I do not want New England Baptist Hospital to release to the above referenced individual(s) or organizations.

I understand that once the hospital discloses my health information to the recipient, the hospital cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Authorization expires on: _____
I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the hospital's Health Information Management Department at the address listed above. The revocation will be effective immediately upon the hospital's receipt of my written notice, except that the revocation will not have any effect on any action taken by the hospital in reliance on this Authorization before it received my written notice of revocation.
Note: This authorization for release of health information (unless expressly revoked earlier) expires six (6) months after the below date, except to the extent that the hospital has already acted in reliance on it. Any information added to the record after the date of authorization cannot be sent until an updated authorization is received.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the New England Baptist Hospital to use or disclose my health information in the manner described above.

_____ _____
Signature of Patient Date

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

Signature of Personal Representative	Description of Authority	Date