McLean Hospital
115 Mill Street, Belmont, Massachusetts 02478-9106
Telephone 617 855-2000, FAX 617 855-3299
Medical Records Department
Telephone 617 855-2447, FAX 617 855-2727

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

!! **Please be careful to complete the correct section(s) of this form, indicating if you wish information to be released FROM McLean Hospital to another person or facility, or from another person or facility TO McLean Hospital.** !!

Specific information to be released:
- ☐ Verbal/Telephone Update
- ☐ Discharge Summary/Summary of Treatment
- ☐ Other *(specify)*_____

Purpose:
- ☐ Treatment
- ☐ Financial
- ☐ Personal
- ☐ Other_____

FROM McLean Hospital
to another person or facility

I hereby authorize McLean Hospital to release the above information

To: ☐ Referring Clinician ☐ PCP ☐ Other

*Name/Title:*_____

*Address:*_____

To: ☐ Referring Clinician ☐ PCP ☐ Other

*Name/Title:*_____

*Address:*_____

TO McLean Hospital
from another person or facility

I hereby authorize the following person or facility to release the above information to

_____ at

McLean Hospital
115 Mill Street
Belmont, MA 02478-9106

From:

*Name/Title:*_____

*Address:*_____

I understand that this information is not to be re-released to any person or facility except as provided by law. This release will expire 90 days from the date below or as otherwise specified:_____. I understand that I may revoke this release of information at any time. I understand, however, that any release which was made prior to my revocation and which was made in reliance upon this authorization shall not constitute a breach of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization to release information shall expire when the desired information is sent.

To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

Signature of Patient (if 18 or older);
or Parent (if patient is under 18);
or Legal Guardian; or Health Care Agent *(circle one)*

Signature of Witness

Printed Name of Patient or Authorized Person Date

Printed Name of Witness Date

HIV Release of Information. (Complete and *sign* all sections above and *sign* below) To the extent that my medical record contains information concerning HIV (HTLV-III) antibody and antigen testing that is protected by M.G.L. Ch.111 §70f, I authorize disclosure of such information for the following purpose:_____.

Signature of Patient or Authorized Person

Signature of Witness

Printed Name of Patient or Authorized Person Date

Printed Name of Witness Date