Joslin Diabetes Center
HIM Department
1 Joslin Pl, 101-F
Boston, MA 02215
Ph: 617-309-2518
F: 617-309-5706

Joslin Diabetes

AUTHORIZATION FOR THE RELEASE OF EXTERNAL PROTECTED HEALTH INFORMATION (PHI)

This document authorizes the below named facility to disclose information as described to Joslin Diabetes Center

Section 1: Patient Data

Name: _____

Address: _____

_____

Date of Birth: _____

Joslin Medical Record Number: _____

Section 2: Releasing Institution

Facility Name:_____

Attn: (Department or Provider) _____

Address: _____

_____

Fax: _____

Phone: _____

Section 3: Type(s) of Information to be Released

Please check any/all appropriate boxes and indicate date range

☐ Office Notes ONLY: _____ to _____

☐ Lab Results ONLY: _____ to _____

☐ Complete Medical Record (includes all listed above) _____ to _____

☐ Other *Please describe:* _____

Section 3 Continued

Additionally, I authorize to disclose PHI regarding the following information, if contained within the requested records:

☐ Alcohol and or Substance Abuse
☐ HIV/AIDS testing/related
☐ STD
☐ Domestic Violence/Abuse
☐ Mental Health (not including psychotherapy notes)
☐ Sexual Assault/Abuse

The Records are for a Joslin appointment on: _____

This authorization should expire: _____

Authorization will be valid for ONE YEAR after the date of signature, unless otherwise stated with the exception of sensitive information indicated above which must be authorized at each request.

Section 4: Signature

By signing this document, I authorize the medical provider listed above (section 2) to disclose my health information as described to Joslin Diabetes Center. I understand that I have right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Joslin Health Information Management Department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal privacy laws and regulations. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that I have the right to inspect or copy the PHI described by this authorization.

I have read this form and accept all of the above.

_____ _____
Signature **Date**

_____
Printed name

_____
Relationship (if signed by someone other than the patient)

PLEASE MAIL THIS FORM TO THE RELEASING INSTITUTION LISTED IN SECTION 2.
THIS FORM SHOULD NOT BE RETURNED TO THE JOSLIN DIABETES CENTER.

For questions or assistance with this form:

Shalena Bonnett
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Boston, MA 02215
Phone: (617) 309-2518 Fax: (617) 309-5706