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

Joslin Diabetes

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION (PHI)

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

Patient

Name: _____

Address: _____

_____

Date of Birth: _____

Joslin Medical Record Number: _____

Authorized Party/Parties

Use additional forms as needed per authorization

I authorize Joslin Diabetes Center to share my medical information with the following individual(s):

Name: _____

Address: _____

_____

Phone Number: _____

Relationship to Patient: _____

Signature

I understand that this authorization does **not** extend to sensitive data including: alcohol/drug abuse, AIDs/HIV, STD testing and information, sexual abuse/assault, domestic violence, communication with mental health or social workers. I understand I have the right to revoke this authorization at any time. I also understand that if I revoke this authorization I must do so in writing and present written revocation to the HIM department at the address stated below. I understand that the healthcare services I receive at Joslin Diabetes Center and any payment for such services will not be affected if I refuse to sign this form. I understand that once the above information is disclosed, the recipient may re-disclose it and the information may not be protected by federal or state privacy laws. Please be aware that hard copies of medical records will not be released to the named individuals: this authorization is for verbal communications only.

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

_____ _____

Signature **Date**

Form should be returned to:

Shalena Bonnett
Health Information Management Supervisor
1 Joslin Place, Room 101-F
Boston, MA 02215
Phone: (617) 309-2518 Fax: (617) 309-5706