

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

F: 617-309-5706

AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION (PHI)

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

Patient Name:	
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 in 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 retuse to sign this form. I understand to note 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 Date Form should be returned to: Shalena Bonnett Health information Management Supervisor 1 Josin Place, Room 101-F Boston, NM 02215	<u>Patient</u>
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Revised 11/2019