Massachusetts Eye and Ear

Authorization for Use & Disclosure of Health Information

Patient Name_____ Date of Birth_____ Date_____
Address:_____ Phone_____

I authorize Massachusetts Eye and Ear Infirmary and Massachusetts Eye and Ear Associates, Inc. (together referred to as "Mass Eye and Ear") to disclose my protected health information to the person or class of persons listed below:

Type of Information to be used or disclosed:

☐ The entire clinical/medical record (all information) ☐ Only the of events from_____ to _____ ☐ All information in my clinically/medical record related to services provided to me in the following department:_____	☐ All information in my clinically/medical record related to services provided to me by the following physician:_____ ☐ Other (describe as specifically as possible): _____ _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below.

☐ Alcohol/Drug Abuse Treatment/Referral ☐ Information about HIV/AIDS-related Testing or Treatment	☐ Information about Sexually Transmitted Diseases ☐ Information about mental illness or health ☐ Information about Sexual Abuse or Neglect
☐ Psychotherapy Notes ONLY *In order to authorize the use or disclosure of psychotherapy notes, only this box can be checked on this form. Authorizations for the use or disclosure of other health record information may not be made in conjunction with Authorizations pertaining to psychotherapy notes*	

Recipient of Information – The information may be used by, or disclosed to, the following individual(s) or organizations(s):

☐ Recipient / Address	☐ Recipient / Address

Purpose of the Use/Disclosure – The information identified above will be used for the following purposes:

☐ Continuing medical care	☐ My personal records	☐ Sharing with other health providers (as needed)
☐ Legal matter		☐ Insurance (such as health, life, or disability insurance)
☐ Other		

Authorization Agreement

- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I understand that I may revoke this authorization at any time by notifying Mass. Eye and Ear in writing and that if I choose to do so, my request to revoke will not apply to information that has already been released in response to this authorization.
- I understand that I may refuse to sign this authorization. My refusal does not affect my treatment, payment or eligibility for care.
- This authorization will expire within 6 months of this request unless otherwise specified.

_____ _____
Signature of Patient or Personal Representative | Relationship if signed by Personal Rep.

_____ _____
Print Name | Date

Return completed form to:
Health Information Services / Medical Records
Massachusetts Eye and Ear
243 Charles Street, M Floor
Boston, MA 02114

Return completed form to:
Completed forms may also be faxed to: 617-573-4380

If you have any questions about this form, please call: 617-573-3356