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 PROTECTED HEALTH INFORMATION (PHI)

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

Section 1: Patient Data

Name: ____

Address: ____

____

Date of Birth: ____________________________

Joslin Medical Record Number: ____________________________

Section 2: 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 _______________

☐ Eye Records ONLY:

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

☐ Other *Please describe:* ____

If no date range is indicated information from the past one year will be provided.

Additionally, I authorize Joslin Diabetes Center 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

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 3: Reason for Release

☐ LEGAL* ☐ PERSONAL* ☐ MEDICAL CARE/RESEARCH

☐ FUNDRAISING/MARKETING ☐ OTHER ______________________

Please be advised: Under certain circumstances a fee will be incurred. In those cases an invoice will be included with requested records

Section 4: Receiving Institution

Use additional sheets if necessary

Facility Name:____

Attn: (Department or Provider) ______________________________________

Address: ____

____

Fax: ______________________________

Phone: ______________________________

Section 5: Signature

By signing this document, I authorize Joslin Diabetes to use and disclose my health information as described above. 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)

For questions or assistance with this form:

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