Joslin Diabetes Center
One Joslin Place
Boston, MA 02215
Tel: (617) 309-2518

Patient Name: _____

Date of Birth: _____

REQUEST FOR EXTERNAL PROTECTED HEALTH INFORMATION (PHI)

By signing this document, I authorize the medical provider listed below to use or disclose my health information as described below to:

Records Requested From:	**Records to be sent to:**
Provider: _____ Address: _____ City, State, Zip: _____ Phone/Fax: _____	Health Information Management Joslin Diabetes Center One Joslin Place, Room 101F Boston, MA 02215

The records requested are for the purpose of a medical appointment on _____
(Date of Appointment if known)

with _____.
(Name of Joslin Provider)

Type(s) of information to be released (check all appropriate boxes).

☐ Office Notes (dates/time frame: _____ to _____)		☐ Medical Records (last 2 years)
☐ Eye Records	☐ Eye Photographs	☐ Medical Records (last 5 years)
☐ Lab Results (note specific dates if necessary)		
☐ Other (please describe):		

Additionally, I authorize the above named provider to disclose PHI regarding the following information, if contained in my record:

☐ Alcohol or Substance Abuse	☐ HIV/AIDS/ARC	☐ Sexually Transmitted Diseases
☐ Domestic Violence	☐ Sexual Assault/Abuse	☐ Communications with mental health, psychiatry and/or social workers

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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.

This authorization will expire on/in _____.

If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed, with the exception of my authorization for AIDS/HIV/ARC information, which must be renewed for each request.

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.

_____ _____

Signature Date

_____

Relationship to patient if signed by legal representative
(Please provide supporting documentation)

Please submit this completed form to the outside provider you would like to send your medical records to Joslin.

For questions regarding your Joslin Medical Records, please contact:
Shalena Bonnett, Supervisor
Health Information Management
Joslin Diabetes Center
One Joslin Place, Room 101-F
Boston, MA 02215
Phone: (617) 309-2518
Fax: (617) 309-5705