BOSTONSIGHT

BostonSight (HIPAA) MEDICAL RECORDS RELEASE FORM

Permission to Share Information

If you want the BostonSight to share information about you with another person or organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, _____ , give my permission for BostonSight
(print your name) (DOB)

to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information

Please check the information you wish to be released

☐ Last 3 BostonSight exam notes

☐ BostonSight Exam notes Date_____ to _____

☐ Other (Specific records and dates) _____

The last three visit dates will be processed free of charge. A basefee of $15.00 will apply for each request beyond that as well as a copying charge of $0.50 per page for the first 100 pages and $0.25 per page in excess of 100 pages.

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

_____I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

____I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request," if you are initiating the request.

_____

_____

_____

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

BostonSight
464 Hillside Avenue
Needham, MA 02494
781-726-7337

BostonSight
Authorization for Release of Information

SECTION V – Who May Receive My Information
The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

Name

Organization

Address

Method of delivery: ☐ Fax ☐ Mail ☐ E-Mail

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts
This permission to share my information is good until _____
Indicate date or event

If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to BostonSight, and send it or bring it to the place where I am now giving this permission. If the information has already been given out by BostonSight, I understand that it is too late for me to change my mind and cancel the permission.

- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature
Please sign and date this form, and print your name

Your Signature Date

Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: _____

Signature of the person filling out this form: _____

Describe how this person has legal authority for this individual: _____