UMASS BOSTON
University of Massachusetts Boston
University Health Services

100 Morrissey Boulevard
Boston, MA 02125
Phone: 617-287-5660
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AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

PRINT CLEARLY

Patient Name _____ ID# _____ DOB:_____

Address_____ Phone_____

City/State/Zip_____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone_____ Fax_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone_____Fax_____

To be (choose one) ___ Mail ___ Fax ___ Pick up

(Check all that apply)

___Immunization Records ___General Medicine Clinical Records ___Summary of Mental Health Services
___Include information relating to sexually-transmitted diseases, HIV, sexual assault, alcohol and drug treatment (includes information protected by 42 CFR Part II laws protecting alcohol and drug abuse)
___Domestic Violence ___Only the following information_____

I understand

1. I may revoke this authorization at any time by providing a written notice of revocation as specified by the Notice of Private Practice; however such revocation would not affect any action taken by UHS in reliance on this authorization before receipt of my written revocation.
2. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on whether I provide authorization for any requested use or disclosure by UHS (a) the treatment is research related, (b) the information is needed for health plan eligibility or underwriting determinations or (c) the sole purpose of creating the information is to disclose to a third party.
3. This authorization expires after **six** months.
4. This information used or disclosed pursuant to this authorization, except information protected by federal regulations about confidentiality of drug and alcohol abuse records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

Signature _____ Date _____