



**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:

<input type="checkbox"/> The entire clinical/medical record (all information) <input type="checkbox"/> Only events from _____ to _____ <input type="checkbox"/> All information in my clinically/medical record related to services provided to me in the following department: _____	<input type="checkbox"/> All information in my clinically/medical record related to services provided to me by the following physician: _____ <input type="checkbox"/> Other (describe as specifically as possible): _____ _____
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**If you would like any of the following sensitive information disclosed, check the applicable box(es) below.**

<input type="checkbox"/> Alcohol/Drug Abuse Treatment/Referral <input type="checkbox"/> Information about HIV/AIDS-related Testing or Treatment	<input type="checkbox"/> Information about Sexually Transmitted Diseases <input type="checkbox"/> Information about mental illness or health <input type="checkbox"/> Information about Sexual Abuse or Neglect <input type="checkbox"/> Genetic Testing/Information
<input type="checkbox"/> Psychotherapy Notes ONLY <i>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</i>	

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

<input type="checkbox"/> Paper Copy Recipient / Address Address <b>RECORDS DEPOSITION SERVICE, INC.</b> PO BOX 5054, SOUTHFIELD, MI, 48086-5054, P: 248-357-3330	<input type="checkbox"/> Electronic Copy / Email Address _____	<input type="checkbox"/> Paper Copy Recipient / Address Address _____	<input type="checkbox"/> Electronic Copy / Email Address _____
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**Purpose of the Use/Disclosure** – The information identified above will be used for the following purposes:

<input type="checkbox"/> Continuing medical care	<input type="checkbox"/> My personal records	<input type="checkbox"/> Sharing with other health providers (as needed)
<input type="checkbox"/> Legal matter		<input type="checkbox"/> Insurance (such as health, life, or disability insurance)
<input checked="" type="checkbox"/> Other PRE TRIAL DISCOVERY		

**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 upon fulfillment of the request unless I specify a different expiration date or 6 months from the date signed

\_\_\_\_\_  
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:**

Fax: 617-573-4380  
 Email: MedicalRecordsROI@meei.harvard.edu  
 If you have any questions about this form, please call: 617-573-3356