MIT Health
Massachusetts Institute of Technology
77 Massachusetts Ave, Building E23
Cambridge, MA 02139

Release of Medical Records

MIT Health recognizes the patient's right to confidentiality of protected health information as set forth in federal and Massachusetts state law. You should be aware of these guidelines when requesting medical records.

State and federal laws recognize the need for written authorization.

All releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information on care provided after the date of the patient's signature, unless you (the patient or personal representative) specify release of future records of a specific test, specific clinic appointment, etc.

If the patient is 18 years or older, the patient must sign the release unless:

- The patient is incompetent,
- The patient is disabled and cannot sign the form,
- The patient is deceased. (The surviving spouse or legal representative with legal proof must sign the authorization for release of the deceased patient's records.)

If the patient is 18 years or younger, the patient must sign the release if:

- The patient is an MIT student, regardless of age,
- The patient is 14 years or older and the records involve treatment for mental illness, alcohol or drug abuse/treatment, domestic/sexual assault, or AIDS testing,
- The patient's records for release include an abortion procedure.

Please read before completing the form below:

This form must be completed in its entirety and signed by the patient or personal representative to be a valid authorization. Incorrect or incomplete forms will not be processed. Anyone other than the patient who signs this authorization for release of records must state his or her relationship to the patient and provide proof of legal authority to release the records.

Once complete please send to MediCopy Services

8 City Blvd., Ste 400 Nashville, TN 37209

P: 866-587-6274 • F: 615-780-9866 • request@medicopy.net.

Please complete the following:

Patient Information

Patient Name _____ (First Name / Middle Initial / Last Name) Date of Birth _____ (month / day / year)

Preferred Name _____ Gender _____

Pronouns _____ MIT ID# _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Where Are We Sending the Records?

Name _____

Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

What Would You Like Released? Check All That Apply

☐ All Medical Records ☐ Office/Clinic Notes ☐ Operative Reports ☐ EKG/Echos/Stress Test

☐ Lab/Pathology Results ☐ Radiology Reports ☐ Immunization Records

☐ Last Two Years of Records ☐ Dates _____ to _____

☐ Other (specify): _____

☐ Verbal Communication Only — specific topic or MIT Health visit(s) that may be discussed:

_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, *if any* ☐ AIDS/HIV/STDs, *if any*

☐ Psychological/Psychiatric conditions, *if any* ☐ Genetic Testing

Purpose of Disclosure: Why are we sending the records?

☐ Personal Use ☐ Litigation/Legal ☐ Insurance ☐ Continuation of Care

☐ Transfer to New Physician ☐ Disability Determination

Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ Postage (additional fee applies)

Patient's Signature

I hereby authorize MediCopy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, unless otherwise noted. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient listed above and will no longer be protected by federal regulations. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient/Personal Representative's Signature _____ Date: _____

If signed by a personal representative: (a) print your name:

_____

(b) indicate your relationship to the patient and/or reason and legal authority for signing:

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased