

# Authorization for Use and Disclosure of Protected Health Information

## MIT MEDICAL — MENTAL HEALTH SERVICE

Massachusetts Institute of Technology  
Mental Health Service – Building E23-368  
77 Massachusetts Ave., Cambridge, MA 02139

Tel: 617-253-2916  
Fax: 617-253-0162

1. Patient last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle initial \_\_\_\_\_ DOB \_\_\_\_\_  
Patient former name: \_\_\_\_\_ MIT ID/SSN: \_\_\_\_\_ MRN: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Patient e-mail \_\_\_\_\_  
Patient home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_

2. I authorize the MIT Medical Department to release or disclose: (information to be released, check one)

My entire mental health record  Only those portions pertaining to (be specific; include provider name and date(s) of treatment, if applicable):

3. Disclose record to: Name/Facility: \_\_\_\_\_ Address: \_\_\_\_\_  
Attention: \_\_\_\_\_

4. Reason for disclosure:

Further mental health care  Payment of insurance claim  Legal investigation  Applying for insurance  
 Vocational rehab, evaluation  Disability determination  At the request of the individual  
 Other – specify: \_\_\_\_\_

5 Under Massachusetts state law, MIT cannot release certain information unless you give us special permission to release it.

Abortion  AIDS/ARC  Alcoholism  Developmental disabilities  
 Domestic/sexual abuse  Genetic testing  HIV testing and related information  
 Privileged information  Substance abuse  Sexually transmitted diseases (STD)  
 Other – specify: \_\_\_\_\_

6. This authorization is valid for PHI disclosures to the recipient above for a period of six months, and it automatically expires in six months from \_\_\_\_\_ (same date as date signed). I understand that I am responsible to notify Mental Health Service of visit(s) that I wish to have disclosed to this recipient. I understand that I may revoke this authorization by providing a written statement to the MIT Mental Health Service, except to the extent that MIT Mental Health Service has already completed the action on it.

7. I understand that protected health information released pursuant to this authorization may be re-disclosed by the recipient(s) on this form to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the MIT Medical Department from all legal responsibilities and liabilities that may arise from the release of the information.

8. Signature of patient/personal representative \_\_\_\_\_ Date \_\_\_\_\_

If signed by personal representative, please print name: \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient and/or reason and legal authority to sign:

Patient is:  minor  incompetent  disabled  deceased  
Legal authority:  legal guardian  next of kin of deceased

9. Signature of witness \_\_\_\_\_ Date \_\_\_\_\_

### MIT Medical Mental Health Service use only

Date received \_\_\_\_\_ I.D. provided \_\_\_\_\_ Date released \_\_\_\_\_

Processed by \_\_\_\_\_  Sent by mail  Picked up in person