WENTWORTH-DOUGLASS HOSPITAL
A Mass General Community Hospital

# PERMISSION FOR HEALTH CARE PROVIDERS TO DISCUSS MY HEALTH CARE WITH FAMILY MEMBERS AND FRIENDS

Patient Identification Area

**Patient Name:** _____ **Date of Birth:** _____ **MRN:** _____

I hereby authorize_____ **permission to discuss** my health information with the following person(s):
**NOTE**: This permission does not authorize these individuals to make health care decisions on my behalf.

*Name:* _____

*Address:* _____

_____

_____

*Phone:* _____

*Name:* _____

*Address:* _____

_____

_____

*Phone:* _____

**Privileged Health Information**. Please check the box below to indicate that we may discuss the information below with the individuals above (if in your medical record)

- ❑ **Mental Health Information**. I authorize discussion of such information, including details of mental health diagnosis, and/or treatment provided by a Psychiatrist, Psychologist, Licensed Mental Health Clinician, Advanced Practice Nurse, or Licensed Social Worker.
- ❑ **Alcohol and Drug Abuse Treatment**. To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2
- ❑ **HIV Information**. To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. Ch. 111 §70f.
- ❑ **Genetic Screening** test results
- ❑ Confidential Communications with a Licensed Social Worker
- ❑ Details of Domestic Violence Victims' Counseling
- ❑ Details of Sexual Assault Counseling

I understand that:

- I may withdraw my permission to discuss my information at any time through written request to the Director of Health Information Management. Removal of permission to discuss will prevent any future communication from taking place.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare.
- This authorization is good for a maximum period of 12 months from the date signed, unless shorter as indicated here:

  _____

**Patient or Patient Representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do *not* sign a blank form.**

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient (if 18 or older);<br>*or* Parent (if patient is under 18);<br>*or* Legal Guardian; or Health Care Agent *(circle one)* | Printed Name of Patient<br>*or* Authorized Individual | Date |