



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**  
**Braintree Rehabilitation Hospital**  
**250 Pond Street, Braintree, MA 02184**  
**Phone: 781-348-2120; Fax: 781-848-5821**

**1. Patient Information**

Patient Full Name: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_ City, ST, Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Other Name During Treatment? \_\_\_\_\_

**2. Release Information To (see back of form to list additional release locations)**

**-This Box Must Be Complete In Order For Request To Be Processed-**

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
 Address: \_\_\_\_\_ City, ST, Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Purpose of Request:  Personal  Treatment  Legal  Insurance  Disability  Marketing  
 Transfer/Reason: \_\_\_\_\_  Other: \_\_\_\_\_

**A fee will be charged for all requests going to self or for transfer of care.**

**3. Information to be Released**

**Treatment Dates:** \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Summary Material  Transcribed Reports  Consultation Reports  Progress Notes  
 Discharge Summary  Physician Orders  Therapy Notes  Billing Statements  
 X-Ray/Diagnostic  Lab Results  Other: \_\_\_\_\_

**Patient copies fees are based upon Massachusetts Law: \$18.60 Base charge and .33 per page.**

**4. Authorization to Release Sensitive Information**

**Required** – Please complete the check boxes and initial lines below indicating how sensitive information should be handled.

<u>Check One</u>	<u>Initial each line below</u>
I <input type="radio"/> DO <input type="radio"/> DO NOT <input type="radio"/> N/A want information about <b>Mental Health</b> released	_____
I <input type="radio"/> DO <input type="radio"/> DO NOT <input type="radio"/> N/A want information about <b>HIV/AIDS Information</b> released	_____
I <input type="radio"/> DO <input type="radio"/> DO NOT <input type="radio"/> N/A want information about <b>Alcohol/Substance Abuse</b> released	_____
I <input type="radio"/> DO <input type="radio"/> DO NOT <input type="radio"/> N/A want information about _____ released	_____
<b>Other sensitive info</b>	



**Please confirm that you have put a checkmark and initialed all the sensitive information categories above regardless if they are applicable or not. If this box is incomplete or if sensitive information is not initialed, we may be unable to fulfill this request.**

- I understand this authorization expires in 90 days from the signature date appearing below unless otherwise noted in the following space: \_\_\_\_\_.
- I understand that I may revoke this authorization at any time by notifying the Health Information Management Department in writing, but if I do revoke, it would not have any effect on information released by the hospital before it received the revocation.
- I understand that under the applicable law, the information used or described pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to the protections of the privacy standard.
- I understand that my treatment or continued treatment by Five Star Quality Care, Inc. and its affiliates is not conditioned on whether or not I sign this authorization. I know that I may refuse to sign this authorization.
- I understand that release of my information to Five Star Quality Care, Inc. or its use by Five Star Quality Care, Inc. for marketing purpose(s) may result in direct or indirect remuneration to Five Star Quality Care, Inc.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Patient/Legal Guardian)

**Legal Guardian: Request is only valid if documentation is attached that validates your authority.**



**2b. Release Information To**

**-This Box Must Be Complete In Order For Request To Be Processed-**

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
Address: \_\_\_\_\_ City, ST, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Purpose of Request:  Personal  Treatment  Legal  Insurance  Disability  Marketing  
 Transfer/Reason: \_\_\_\_\_  Other: \_\_\_\_\_

**A fee will be charged for all requests going to self or for transfer of care.**

**2c. Release Information To**

**-This Box Must Be Complete In Order For Request To Be Processed-**

Name/Facility: \_\_\_\_\_ Attention: \_\_\_\_\_  
Address: \_\_\_\_\_ City, ST, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Purpose of Request:  Personal  Treatment  Legal  Insurance  Disability  Marketing  
 Transfer/Reason: \_\_\_\_\_  Other: \_\_\_\_\_

**A fee will be charged for all requests going to self or for transfer of care.**