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

MIT Health
Student Mental Health & Counseling

Authorization for Release of Protected Health Information

Disclosure of Protected Mental Health Information (PHI) to MIT Health

1. Patient Information

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

Preferred Name _____ Gender _____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

2. Information to be Disclosed

I herby authorize _____ Phone _____

Address _____ City _____ State _____ Zip _____

to disclose a copy of my:

- ☐ Admission Notes
- ☐ Progress Notes
- ☐ Office Notes
- ☐ Lab Reports
- ☐ Hist & Phys
- ☐ Consult Report
- ☐ Emergency Service Report
- ☐ Entire Mental Health Record
- ☐ Other (specify): _____

3. Recipient Authorization

To the attention of: _____ at MIT Health Student Mental Health and Counseling Services, 77 Massachusetts Ave E23 for further medical care.

4. Release of Privilege Information

- ☐ Abortion
- ☐ AIDS/ARC
- ☐ HIV Testing and related information
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Genetic Testing
- ☐ Domestic/Sexual abuse
- ☐ Developmental disabilities
- ☐ Other (specify): _____

5. Patient Rights and Privacy

I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to MIT Health's Student Mental Health & Counseling Services, except to the extent that Student Mental Health & Counseling Services has already completed action on it.

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

I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

6. Signature of Patient or Personal Representative: _____ _____
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

Submitting this form

Once complete, please send to MIT's Student Mental Health & Counseling Services:

77 Massachusetts Ave., E23
Cambridge, MA 02139
Fax: 877-932-6537

For MIT's Student Mental Health & Counseling Services use only:

Date _____ Received by: _____ ID provided: _____ received MRN: _____

Date released: _____ Processed by: _____ ☐ Sent by FedEx ☐ Picked up in person