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

Authorization for the Release of Protected Health Information (PHI)

Please print clearly, fill out the form completely, and email it to help@recordquest.com.

Patient name _____ **Date of birth** _____
(first, last)

Patient preferred name _____ **Name (if not patient)** _____

Relationship to patient _____ **MIT ID # (if applicable)** _____

Provider authorized to release PHI:
MIT Health
77 Massachusetts Ave, E23
Cambridge, MA 02139

Request Records Online
AskforRecords/MIT

Entity receiving the protected health information

Name / Company _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____

Email _____

Preferred delivery method ☐ Email (Recommended) ☐ Fax ☐ Mail

Information requested

Purpose for this disclosure _____

Dates of service _____ to _____

Chart sections

- ☐ Complete Medical Record
- ☐ Office/Clinical Notes
- ☐ Laboratory/Pathology Results
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ OB/GYN Records
- ☐ Complete Dental Record
- ☐ Dental Imaging
- ☐ Radiology Images

Additional comments _____

Release the following types of information

HIV /AIDS Related ☐ Yes ☐ No
Alcohol / Drug Treatment ☐ Yes ☐ No
Psychiatric / Mental Health ☐ Yes ☐ No
Genetic Testing ☐ Yes ☐ No

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid 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 of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of patient or personal representative _____ **Date** _____

MIT Health has partnered with RecordQuest to make requesting medical records easier. You may receive ommunications from RecordQuest during this process. Any information you share is used strictly to fulfill your request.RecordQuest | www.recordquest.com | 888-300-7410 | help@recordquest.com