Steward Medical Group
Authorization to Use and Disclose Protected Health Information

1) I hereby ______________________________________ to disclose the protected health information of the patient
Name of Facility or Person
listed below to STEWARD MEDICAL GROUP. I understand the information disclosed pursuant to this authorization could be subject to re-disclosure by the recipient, unless prohibited by law.

---

2) Patient Name:____Date of Birth:____________________
Please Print

Address:____
Street City State Zip

Contact Telephone Number ______________________ Social Security Number ______________________________

3) Disclose To:

STEWARD DIVISION OF UROLOGY
11 NEVINS STREET, MOB 303
BRIGHTON, MA 02135

Fax #___617-787-4644______

Phone#___617-787-8181____

---

4) Treatment Dates: From: ____________________ To: ____________________

SPECIFIC REPORT(S) REQUESTED:

- ☐ Office/consultation notes
- ☐ Test results
- ☐ Correspondence
- ☐ Immunization history
- ☐ Medication history
- ☐ X-Ray reports
- ☐ Laboratory results
- ☐ Complete record
- ☐ Other Specified
  ____
  ____
  ____

5) My Highly Confidential Information:
By signing below, I specifically authorize the use and/or disclosure of the following types of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization.
(Note to patient: please draw a line through any item/s listed below if you do not want the information disclosed).

- Mammography Records
  (except to requesting MD or patient)
- Mental Health Communications
- Psychotherapy Notes
- Social Worker Communication
- Developmental Disability
- HIV/AIDS Testing, Results or Treatment
- Treatment or of Substance Abuse (alcohol or drug)
- Child/Elder/Disabled Abuse & Neglect
- Rape/Sexual Abuse
- Sexually Transmitted Disease
- Genetic Testing
- If I am an emancipated minor, information about treatment & diagnosis (except to my parents)

X ____ ____________________
Signature of Patient or Legal Representative **Date**

6) Purpose of the Disclosure:

☐ Medical Care ☐ Legal ☐ Insurance ☐ Personal ☐ Other____________________

IMPORTANT: PLEASE SIGN AUTHORIZATION FORM ON PAGE 2 →
THIS AUTHORIZATION SHALL BE DEEMED <u>INVALID</u> UNLESS ALL NUMBERED ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2

7) Revocation: I understand that I may revoke this authorization at any time by requesting such of STEWARD MEDICAL GROUP in writing, unless action has already been taken in reliance upon it, ore during a contestability period under applicable law.

8) Term:

☐ From the date of this Authorization until the ____________________day of___________________200______

☐ Until the following event occurs:____

☐ Other: ____

Access: I understand that I have the right to request access to my Protected Health Information which is maintained by SMG in the SMG's Designated Record Set upon completion of the Authorization to Use and Disclose Protected Health Information. I also understand I have the right to request to view and/or have copied my Protected Health Information in its entirety or an abstract. Based on State and Federal Law, SMG has a right to deny me access to all or portions of my Protected Health Information and must notify me in writing. I understand that SMG may charge a reasonable cost based fee associated with copying my Protected Health Information.

I may contact Steward Medical Group's Privacy Office by mail at:
SMG, 77 Warren Street – Room 532, Brighton, MA 02135 or
by telephone at: (617) 562-5333.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize SMG to use or disclose my health information in the manner described above.

9) **X** ____ **10)**____________________________

Signature of Patient **Date**

____ ☐ I.D Verification__________________

Printed Name of Patient Witness

If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signature:

9) **X**____ **10)**____________________________

Signature of Legal Representative **Date**

____ **11)**____

Printed name of Patient Representative Relationship to patient or authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL NUMBERED ENTRIES ARE COMPLETED AND FORM IS SIGNED ON PAGE 2.