COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF CORRECTION
HEALTH SERVICES DIVISION

AUTHORIZATION TO RELEASE SENSITIVE MEDICAL INFORMATION

NAME & ADDRESS OF INMATE
DATE_____

_____

_____ **ID #_____**

_____ **SS #_____**

Date of Birth _____Institution _____

NAME & ADDRESS OF PERSON REQUESTING MEDICAL RECORD (OTHER THAN INMATE)

_____

_____

_____

Purpose of disclosure:_____

Information to be released: _____

_____

_____

I hereby authorize the release of the information stated above, including any information regarding mental health conditions, drugs or alcohol abuse, HIV test results and/or any AIDS related information. Any other use or disclosure of this information is forbidden. This consent will expire on _____or sixty days after today's date. This consent is subject to revocation at any time except to the extent that action has been taken in reliance there on.

_____
Signature of inmate **Date**

_____
Witness **Date**

_____
Additional Signature & Relationship to inmate, if required. Date

If inmate is deceased, please provide proof of executor or administratix.