COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF CORRECTION

AUTHORIZATION FOR THE RELEASE OF PROTECTED RECORDS TO THIRD PARTY
BY ELECTRONIC MAIL

PATIENT'S NAME:_____

ID#_____DATE OF BIRTH_____

INSTITUTION:_____

____To allow _____who is _____
(Name of authorized person) (relationship, i.e., physician, attorney)
to be furnished with the following records (check all that apply) by electronic mail:

( ) MEDICAL RECORD: a complete copy/abstract of my medical record.
Provide dates of service _____
(Specify scope of procedures or N/A)

( ) COVID-19 TEST RESULTS:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

( ) SENSITIVE MEDICAL INFORMATION:

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.

( ) CRIMINAL OFFENDER RECORD INFORMATION (CORI): Records and data which concern me and relate to the nature or disposition of incarceration, rehabilitation, or release, as stated in 103 DOC 153.

Specific document(s) to be released: _____

( ) EVALUATIVE INFORMATION: Classification Reports or any other Department records which concern me and appraise my mental and/or physical condition, extent of social adjustment, and rehabilitative progress, as stated in 103 CMR 157.05.

Specific document(s) to be released: _____

I hereby acknowledge that I have read, or have had read to me, and fully understand the above statements as they apply to me and do herein expressly and voluntarily consent to disclosure for the purpose or need and to the extent or nature as stated. I further understand that I may revoke this consent at any time. Except where disclosure has already been made or upon occurrence of the event: the purpose for which this disclosure is hereby authorized. Deletions may be made as required by the privacy laws of Massachusetts. I hereby acknowledge that the information specified above will be provided to the third party by electronic mail, and expressly consent to

this, and further release the Department of Correction, its representatives, employees, agents, contractors and subcontractors, and the representatives, employees, agents and subcontractors of its contracted medical vendor, from any and all claims, actions, liabilities, damages and causes of action of every name and nature relating to providing this information by electronic mail.

This Authorization for Release of Protected Records to Third Party by Electronic Mail (unless expressly revoked earlier) expires six (6) months from the date last signed by the patient/inmate or authorized agent.

Patient's/Inmate'ssignature_____
Date_____

Witness signature _____Date_____

Copied _____pages @_____Total Paid $_____
pages Price per page

_____Date_____
Additional Signature & Relationship to inmate, if required

_____Date_____
Witness

If inmate is deceased, please provide proof of personal representative, executor or administratix of the deceased's estate.