

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 administratrix.