WINCHESTER HOSPITAL
Winchester, Massachusetts

Section: **Processing/Off Site Specimen Collection**

Title: **Release of Patient Results**

Purpose: **To insure that results are not released over the telephone to a patient.**

Procedure:

1. Results are only given verbally to:

    a. Physician
    b. Physician's office
    c. Specific person designated by the physician.

2. Results may be given to a patient who presents himself/herself at the lab or drawing site and signs a release form. Patients need to be asked for a form of Identification, usually a license. The release must be specific as to what results were released (such as Lab work from 12/5/02). The results for a patient can not be released to anyone else unless there is a written note from the patient with a specific person named (husband, wife, etc.) This person should provide an ID and a copy made. No results will be faxed to a patient home.

3. Pathology or cytology results are not to be released by the laboratory or drawing sites. The patient must go to Health Information Management during their hours of operation.

4. Send the signed consent form to HIM (Health Information Management) at the main hospital, along with a copy of any ID made if not the patient. Please make sure the Medical consent form is filled out completely before sending to HIM. The top four lines to the right need to be completed by the person assisting the patient – not the patient. These four lines include, the Unit (medical record) number, the Account number, the date of service and the initials of the Lab staff assisting the patient.

5. The signed forms will be maintained on file for six months at the HIM Department.

6. If a patient insists on a verbal result, please:

    a. Be courteous.
    b. Explain the policy.
    c. Offer to call the result to the physician and request a call to the patient.
    d. Let them know they may come to the hospital/offsite facility to pickup a copy in person with the exception of pathology and cytology results.
    e. Refer call to the Lab Manager.

NOTE: Do not release a verbal result to a patient except in the case where a physician has approved the release.

Revised:

Unit:_____

Acct:_____

Date of Service:_____

Lab Initials:_____

WINCHESTER HOSPTIAL
Winchester, Massachusetts

AUTHORIZATION FOR RELEASE OF INFORMATION

Health Information Management
41 Highland Ave
Winchester, MA 01890
781-756-2170

Health Records
500 Salem Street
Wilmington, MA 01887
978-988-6113

1. I hereby authorize the entity noticed above to release a copy of the following information from the medical record of:

Name:_____Date of Birth:_____

Address:_____

2. Information to be released to:_____

Address:_____

3. Information is being released for the purpose of:
_____Medical _____Personal _____Legal _____ Insurance Other:_____

4. Information requested to be released, include date(s) of service: _____

_____Discharge Summary
_____ER Report
_____Pathology Report
_____Out Patient
_____History & Physical
_____Operative Report
_____Lab,X-ray,EKG,EEG,EMG
_____Entire Medical Record

Other_____
_____

I authorize this release with the understanding that it my include information in one or more of the following categories (please initial the authorized release)

_____a) information relating to treatment for alcohol or drug abuse
_____b) information relating to sexually transmitted diseases
_____c) information relating to communications with social workers, psychotherapists, psychologists, sexual assault, counselors, Domestic violence counselors, allied mental health professionals, human service professionals
_____d) genetic testing
_____e) abortion information and consent forms

I have carefully read this form and fully understand the above statements as they apply to me. I release the hospital from any liability arising from this authorization. I understand this authorization will expire in 90 days unless otherwise specified by me.

I understand I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of treatment provided to me. I may revoke this authorization by requesting such revocation in writing to the entity noted above, and such revocation shall be effective immediately upon receipt unless action has already been taken in reliance upon it.

Please review Winchester Hospital Notice of Privacy Practices for further information.

I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protesting confidentiality.

I am aware that in accordance with the Massachusetts General Law Chapter 111 Section 70 there may be a fee associated with receiving a photocopy of the requested medical records. Please contact the Health Information/Health Records Department at the above phone numbers for further information.

5._____ _____
Signature of Patient or Patient's Authorized Representative — Date

6._____ _____
Printed name of patient or representative — Relationship to patient or authority to act for