ENGLE LABORATORY | AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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PLEASE DO NOT SEND THIS FORM TO ENGLE LABORATORY UNLESS RELATED TO RECORDS OF BOSTON CHILDREN'S HOSPITAL
Please send the form(s) to the physician offices or institution from which you are requesting records to be sent to the Engle Lab.

1. I authorize the below listed party to disclose the requested protected health information from the medical records of the patient specified on line#2. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

   HEALTH CARE PROVIDER (Physician, Clinic, Hospital):_____

   Address:_____
   Street **City** **State** **Zip**

   FAX#:_____ TELEPHONE#_____

2. **PATIENT NAME**:_____ Date of Birth:_____

   Address:_____
   Street **City** **State** **Zip**

3. Information to be disclosed and sent to:

   Brenda Barry, Genetic Counselor
   Boston Children's Hospital-BCH 3149
   CLS 14076-Engle Laboratory
   Boston, MA 02115
   Phone: (617) 919-2168
   Fax: (617) 730-4834

4. Please disclose the following information (check all that apply):

   - ☐ **Medical Records**: Ophthalmology Procedures, Test Results & Visit Notes
   - ☐ **Medical Records**: Neurology Procedures, Test Results & Visit Notes
   - ☐ **Medical Records**: Genetics Procedures, Test Results & Visit Notes
   - ☐ **Medical Records**: Other Procedures, Test Results & Visit Notes (ex: Orthopedics, Surgery)
   - ☐ **Head Imaging-may include brain MRI, orbit imaging**
   - ☐ **Other**_____

5. The above information is disclosed for the purpose of research or clinical care or both. *Please circle as appropriate.*

6. I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization does not expire, unless specified by this future date:_____

8. Signatures:

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____ _____
Printed Name Patient or Parent/Legal Guardian Relationship to patient/authority to act for patient

INSTRUCTIONS

Line #1: Enter the name of the physician, hospital or institution from which specific records are being requested. You may need to make copies of this form if you are requesting records from multiple locations or facilities. **Line#2**: Enter patient identifiers. **Line #4**: Please check records you are requesting from that location. **Line #8**: Sign, date and print your name at the bottom of the form.

Please send the form(s) to the physician or institution from which you are requesting records. They will then forward records to us.
Please contact us with questions or to check the status of records being received into the lab at the address above or by email noted below.

Email: englegc.research@childrens.harvard.edu