Sample Release Form

Massachusetts General Hospital
Quit Smoking Service
275 Cambridge Street
Boston, MA 02114
Phone: (617) 726-7443
Fax: (617) 724-3544

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ **Date**: _____

Address: _____ MGH # : _____

_____ **Date of Birth**: _____

I hereby authorize the Massachusetts General Hospital to release the information listed below to:
_____

_____

****

Provider Information

I hereby authorize: **Name**: _____

Address: _____

Telephone:_____

Fax: _____

to release the following information to the Massachusetts General Hospital.

Information to be discussed: Recommended approaches to smoking cessation, approval for nicotine replacement and pharmacological management of symptoms of nicotine withdrawal.

I understand that this consent will remain effective for ninety (90) days and is subject to revocation at any time unless action on it has already begun.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CRF 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 regulation. A general authorization for the release of medical or other information not sufficient for this purpose.