walden *behavioral care*

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Is hereby authorized to receive or disclose the following protected health information from the medical or psychiatric records of the patient listed below.

PATIENT INFORMATION:

Patient Name: ______________________________ Date of Birth: ______________

Address ____
Street City State Zip

Telephone: (   ) ______________ Email: ______________________________

Records From:

____
Name

____
Address

____
City State Zip

(   ) ______________ (   ) ______________
Telephone Fax

Records To:

____
Name

____
Address

____
City State Zip

(   ) ______________ (   ) ______________
Telephone Fax

PURPOSE OF THE REQUEST (CHECK ONE):

❑ Medical Care ❑ Legal Care ❑ Insurance ❑ Personal ❑ Other

For Date(s) of Service from: ____________________ to ____________________ (Dates MUST be specified)

INFORMATION TO BE DISCLOSED:

❑ Abstract of Record ❑ Consult ❑ Group/Progress Notes
❑ Discharge Summary ❑ Laboratory Reports ❑ Any and All Records
❑ History & Physical ❑ Assessments ❑ Other (specified) ____________________

FORM DISCLOSURE:

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

SPECIFICALLY AUTHORIZED RELEASE OF INFORMATION (initial If applicable):

I understand that my health information may contain the following types of sensitive information and I expressly and voluntarily give permission to release the following:

____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c. 111 70F, an HIV/AIDS diagnosis or treatment. I specifically authorize disclosure of this information.

____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2. I specifically authorize disclosure of such information.

____ Release Psychiatric & Mental Health/Behavioral Health Records. Psychotherapy Records will NOT be released. Release of Psychotherapy Records requires a separate release form

____ Release Sexually Transmitted Diseases

I UNDERSTAND THAT:

- I may refuse to sign this authorization.
- The original or a copy of this authorization shall be included with my original records.
- Unless otherwise revoked, this Authorization expires ________________________ (insert applicable date or event). If no date is indicated, the Authorization will expire 30 days after the date of signature.
- I understand that this authorization will remain in effect until the term of this authorization expires, or I provide a written notice of revocation. The revocation will go into effect immediately upon receipt, except that it will not apply to any action taken by the hospital before receipt of the written notice of revocation.
- I understand that pursuant to HIPAA 45 CFR, 164.524, Walden Behavioral Care reserves the right to charge a reasonable cost-based for producing and mailing the copies. At no time will the cost-based fees exceed Massachusetts law (MGL Chapter 111; Section 70).
- I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Walden Behavioral Care.
- I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize disclosure of the above protected health information to the persons or agencies listed above.

____

Signature of Patient or Legal Guardian Date

____

Printed Name of Patient or Legal Guardian Date

OFFICE USE ONLY

Date Records Copied: ____________________________ Copied By: ______________________________

Medical Copies sent via: ❑ Mail ❑ Patient Pickup ❑ Fax to : ______________________________