walden behavioral care

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

9 Hope Ave., Suite 500 **Waltham, MA 02453**	**150 Grossman Dr., Suite 404** **Braintree, MA 02184**	**335 Chandler St., Suite 3** **Worcester, MA 01602**	**WBC CT East** **2400 Tamarack Ave., Suite 203** **South Windsor, CT 06074**	**229 East Main St., Suite 201** **Milford, MA 01757**
69 Hickory Dr., Suite 2000 **Waltham, MA 02451**	**100 University Dr., Second Fl.** **Amherst, MA 01002**	**2 Corporation Way, Suite 260** **Peabody, MA 01960**	**157 Goose Lane, Suite 100** **Guilford, CT 06437**	**310 Barnstable Road, Suite 204** **Hyannis, MA 02601**

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

Patient Name: _____ Date of Birth: _____

Address _____
Street City State Zip

Telephone: ( ) Email:

Information to be disclosed to
Or received from: _____
Name

_____
Address

_____
City State Zip

Email: Telephone: ( ) Fax: ( )

Disclose the following information for treatment dates _____ to _____

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:

- ☐ Discharge Summary
- ☐ Abstract of Record
- ☐ History & Physical
- ☐ Consult
- ☐ Laboratory Results
- ☐ STD
- ☐ Psychiatric Evaluation
- ☐ Assessments
- ☐ Group/Progress Notes
- ☐ Alcohol/Substance Use
- ☐ All information pertaining to care and treatment
- ☐ Other (specified): _____ _____

Specifically Authorized Release of Information (initial if applicable)

____ 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.

The above information is disclosed for the following purposes:

☐ Medical Care ☐ Legal Care ☐ Insurance ☐ Personal ☐ Other

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital in writing, unless action has already been taken in reliance upon it.

This authorization expires 90 days from _____or 90 days from date of discharge.

_____
Signature of Patient or Legal Guardian Date

_____
Printed Name of Patient or Legal Guardian Date

♦A photocopy of this form shall have the same effect as the original ♦