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 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 Request to Release:

❑ 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) _____

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 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.
- 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 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.

_____
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 : _____