AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

Full Name: _____ *Date Of Birth:* _____

Address: _____ *Home Phone:* _____ *Sex:* *M / F*

By signing this Authorization, I authorize the use or disclosure of my confidential and/ or Protected Health Information **maintained by: BEHAVIORAL HEALTHCARE SERVICES 435 Shrewsbury Street, Worcester, Ma. 01604**
My health information may be **disclosed** under this Authorization to:

PCP (Primary Care Provider)/AGENCY/PERSON: _____

ADDRESS: _____

PHONE; _____ **FAX:** _____

SCOPE OF USE OR DISCLOSURE: **PLEASE INITIAL** ALL THAT APPLY

_____ **All health information about me,** including my clinical records, including all psychiatric information created or received by the agency, for all dates of service.

_____ Initial here if you are allowing written and verbal **two-way communication** of protected health information between the people/parties listed above.

_____ Information pertaining to the identity, diagnosis, prognosis or **treatment for alcohol or drug abuse** maintained by a federally-assisted alcohol or drug program.

_____ Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.

Specific health information ***including only*** (list specific dates of services if limited here: _____

PURPOSE OF THE USE OF DISCLOSURE: The purpose(s) of this Authorization is (are):
□Treatment Coordination and Planning □ Initiated by the Patient and the Patient does not elect to disclose its purpose.
Note: this box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.

This Authorization expires: (insert applicable event or date- mm/dd/yy) _____.
I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information. If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more that the length of my care at Behavioral Healthcare Services, except when Federal and/or State regulations specify otherwise. In such situations, the shorter time period shall apply

Patient's Signature: _____ Date: _____

Witness: _____

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required. *
Signature of Legal Representative: _____ Date: _____

Print Name: _____
Relationship of Representative to Client: _____

*If signing as a legal representative, also provide appropriate paperwork to support status.

BEHAVIORAL HEALTHCARE SERVICES
435 Shrewsbury Street, Worcester, MA 01604
TEL 508-753-5554 FAX 508-752-7245
****A copy of completed authorization must be given to patient. ****