Step By Step Supportive Services
1470 Beacon Street, Brookline, MA 02446
Telephone (617) 277-6140

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Client Name:_____ **Date of Birth:** _____ **SS:** _____

Specific Information to Be Released:

- ☐ Admission/Discharge Summaries
- ☐ Psychological Tests
- ☐ Physical Exam
- ☐ Medical Tests/Lab Reports
- ☐ Psychiatrist Treatment
- ☐ Verbal/Telephone Communications
- ☐ Psychiatric Evaluation
- ☐ Biopsychosocial Evaluation
- ☐ Inpatient Records
- ☐ Psychotherapy Treatment
- ☐ Treatment Plans
- ☐ Other _____

Purpose:

- ☐ Evaluation
- ☐ Ongoing Treatment
- ☐ Aftercare Planning
- ☐ Legal Matter
- ☐ Other _____

Additional Request for Information Release:

Please check any of the following items to give permission for the release of information relative to:

- ☐ Alcohol & Drug Abuse Treatment *as protected by 42 CFR, Pt 2*
- ☐ HIV Information *as protected* by M.G.L. Ch.111 §70f
- ☐ Details of Sexual Assault Counseling
- ☐ Details of Domestic Violence Victims' Counseling

☐ I hereby authorize the **following person or facility to release** the above information to Step By Step Supportive Services, Inc.

☐ I hereby authorize **Step By Step Supportive Services, Inc. to release** the above information to the following person or facility:

To: ☐ Referring/Aftercare Clinician ☐ PCP ☐ Other

Name/Facility: _____

Address: _____

It is my understanding that this information will be used solely for the purpose(s) described above. I understand that I may revoke my permission at any time except after the information has already been released and to the extent that action on the release has already begun. This authorization expires one year from date of signature.

I further release Step By Step Supportive Services, Inc. from all legal responsibility or liability that may arise from this disclosure.

Patient or Patient Representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do not sign a blank authorization form.

_____	_____	_____
Signature of Client (if 18 or older); *or* Parent (if Client is under 18); *or* Legal Guardian; or Health Care Agent *(circle one)*	Printed Name of Client or Authorized Person	Date