Behavioral Healthcare Services

435 Shrewsbury Street
Worcester, MA 01604

Phone: 508-753-5554
Fax: 508-752-7245

Authorization for The Disclosure of Protected Health Information

Patient Information

Patient Legal Name: _____ **Date of Birth:** _____

Sex: _____ **Phone:** _____ **Email:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Release Information To

I hereby authorize: **Behavioral Healthcare Services, located at 435 Shrewsbury Street, Worcester, MA, 01604** to use or disclose my confidential and/or protected health information. My health information may be disclosed to the following person/facility:

Name/Facility: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Authorization to *Use or Disclose* Protected Health Information

In order for our office to receive or send any of your protected health information, you must initial on the lines below of what you wish to release.

Initial: _____ I authorize all health information about me, including my clinical records, all psychiatric information created or received by the agency, for all dates of service to disclosed.

Initial: _____ I authorize two-way, verbal, and written communication of protected health information between the parties listed above.

Initial: _____ I authorize information about drug, alcohol and/or substance abuse treatment to be released.

Initial: _____ I authorize information about HIV/AIDS testing and/or treatment to be released.

I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Outpatient Operations.
I understand that I have a right to revoke this authorization. I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

Purpose of this authorization: _____

Unless revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, this authorization will expire one year from the date signed.

Signature: _____ **Date:** _____ **Relationship to Patient:** _____