MEDICAL RECORDS RELEASE

Today's Date: _____
I, the undersigned, understand that my health record may include general information related to my health, drug/alcohol abuse, sexually transmitted diseases, abortion, or other information I may consider sensitive. I understand that this request pertains to information obtained on or before the date signed. I understand and acknowledge the release provided at my initial appointment will be utilized to retrieve my medical records.

Patient Name _____ _____ Date of Birth _____

Address_____City_____ State_____ Zip _____

Phone: _____Cell Phone: _____

◯ ***TO*** BEHAVIORAL HEALTHCARE SERVICES
435 Shrewsbury Street, Worcester, MA 01604
Phone: 508-753-5554 Fax: 508-752-7245

☐Amjad Bahnassi, MD
☐Michael Pizza APRN/BC
☐Kimberly Abdow MS, NP/C
☐Brenda McCarthy-Trayah, LMHC
☐Beth Irving, LICSW
☐George Rhoads, PhD
☐Gwen Carelli MA, LMHC

◯ ***FROM*** Behavioral Healthcare Services to:

Name _____
Address_____
City _____ State _____ ZIP_____
Phone _____ ___ Fax_____

******IMPORTANT NOTICE**: Per Behavioral Healthcare Services Policy, we only copy, print, mail or fax BHS records. We do not copy, print, mail or fax other providers' medical records. Please contact your previous providers for these records.

I UNDERSTAND THAT:

- This authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party (example: employment physical)
- I may inspect or copy information to be disclosed as provided tin the Joint Notice of Information Practices.
- There may be a fee for photocopying my health information
- Any disclosure carries the potential for unauthorized re-disclosure. I release Behavioral Healthcare Services from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke this authorization at any time by presenting a written request. Revocation will not apply to information that has already been release in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy.

Check how records are to be received: ◯ Pick Up ◯ Fax ◯ Mail
(FAX AND MAIL OPTION FOR MEDICAL OR LEGAL ORGANIZATIONS ONLY)

I understand that my request will be processed within the timeframes set forth by state law or within 30 days, whichever is less. I understand that I am responsible for the cost of copies.
A copy of this authorization is as valid as an original and will expire 6 months from the date below.

PRINT NAME* _____ SIGNATURE* _____
WITNESS _____ DATE _____

**If signing as a legal representative, also provide appropriate paperwork to support status.* PLEASE NOTE: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC- 3701.243) and federal law 42 CFR, part II.