New Horizons medical

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

A. Patient's Name:	Date of Birth (m/d/y): / /	Medical :Record Number *(if known)*:
Address:	Telephone Number:	Social Security Number: XXXX-XX-_____

B. Permission to Share: I voluntarily give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form.

____ Check here if you wish for both providers to release information to each other.

Release Information FROM:	**Release Information TO:**
Name:_____	Name:_____
Address:_____	Address:_____
Tel. Number:_____	Tel. Number:_____
FAX Number: _____	FAX Number: _____

C. Reason for Release of Records: _____

D. Information to be released for treatment dates: From _____/_____/_____ through_____/_____/_____
OR Information to be released relative to: _____

E. Documents to be released: (Please check each which applies)

____ Medical Records Abstract (i.e, History, Clinical/Office Notes, Discharge Summary, All Diagnostic Test results)

____ Progress Notes

____ Discharge summary

____ Laboratory Reports

____ Entire Medical Records

F. Privileged or Specifically Protected Information: (Please check each which applies)

____ Alcohol or Drug Abuse Treatment

____ Sexually Transmitted Diseases

____ Sexual Assault Victim Counseling

____ Communication between patient and Social Worker/Therapist

____ Mental Health - mental health information including communication between patient and Psychiatrist, licensed Psychologist, or Therapist

____ HIV/AIDS diagnosis and/or treatment
I specifically give permission to share information in my record about my HIV/AIDS diagnosis and/or treatment information . **Initial here** _____ as required by M.G.L. c.111, § 70F.

G. I understand and agree:

- My substance abuse/mental health records are protected under Federal regulations 42 C.F.R. Part 2 (Confidentiality and Drug Abuse Patient Records), and 45 C.F.R. pts 160 & 164 (Health Insurance Portability and Accountability Act of 1996 ("HIPAA"))
- This information cannot be disclosed without my written consent, except as otherwise provided for by the regulations.
- The information I authorize for release may be re-sent and no longer protected by federal privacy regulations.
- I may rescind this authorization at any time by notifying the physician/medical facility from whom I am requesting this information, provided the information has not already been released.
- I have received a copy of this authorization.

H. This authorization expires upon completion of treatment/discharge from program, when rescinded, or on a specific date: _____/_____/_____

____ Check here if you wish for future records to be released under this completed authorization.

I. **X**_____ _____
Signature of Patient or Authorized Person Print Name

Date: _____ Relationship of Authorized Person to Patient: _____

This information is protected under Federal law may not be further disclosed unless permitted by the regulations.

Rev. 9/23/2020