



# ARBOUR HOSPITAL

A Division Of Arbour Health System

49 Robinwood Avenue, Jamaica Plain, MA 02130 Phone 617-522-4400

Fax Completed Form to 617-390-1574

## AUTHORIZATION TO OBTAIN/RELEASE PSYCHIATRIC/SUBSTANCE ABUSE INFORMATION

Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Phone \_\_\_\_\_

Patient Address \_\_\_\_\_

### I hereby authorize:

Arbour Hospital \_\_\_\_ or Arbour Counseling Services, Jamaica Plain \_\_\_\_

To: (check one) Obtain from \_\_\_\_ or Release to \_\_\_\_

Facility \_\_\_\_\_ Address \_\_\_\_\_

Attention \_\_\_\_\_ Fax # (if applicable) \_\_\_\_\_

The following information contained in the medical/psychiatric/substance abuse record of the above named patient pertaining to services provided on or about \_\_\_\_\_

### Please check the appropriate information to be released:

Admission Note \_\_\_\_ Discharge Summary \_\_\_\_ Consults \_\_\_\_ Treatment Plan \_\_\_\_ Physical Examination \_\_\_\_

Psychological Tests \_\_\_\_ Lab Work \_\_\_\_ Other (be specific) \_\_\_\_\_

### The information is needed for the following purpose(s) and may not be re-disclosed:

To provide ongoing treatment/aftercare: \_\_\_\_\_

Other: \_\_\_\_\_

### Please check the appropriate statements:

I DO \_\_\_\_ I DO NOT \_\_\_\_ CFR Part H. authorize disclosure of information which refers to treatment or diagnosis of drug or substance abuse which I understand is protected by Federal Regulation: 42

I agree \_\_\_\_ that a copy of this form is valid as the original.

I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of information and /or psychiatric records including Alcohol and Drug Abuse information, if applicable, about my condition and treatment to those persons/agencies named above, provided a release of information is done substantially in accordance with applicable laws. I understand this consent is subject to revocation at any time unless action based on it has already begun. The authorization expires 90 days from this date \_\_\_\_\_

*This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder. Once the requested PHI is disclosed, the Privacy Regulations may no longer protect it, if the PHI's recipient re-discloses it.*

My records may \_\_\_\_ may not be \_\_\_\_ faxed. Please initial \_\_\_\_\_

Date \_\_\_\_\_ PATIENT SIGNATURE \_\_\_\_\_

Date \_\_\_\_\_ WITNESS SIGNATURE \_\_\_\_\_

SIGNATURE OF LEGAL GUARDIAN OR PARENT of patient under 18 \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Date \_\_\_\_\_ ADOLESCENT SIGNATURE \_\_\_\_\_

### Authorization to Release HIV Information

I hereby specifically authorize the release of HIV (HTLV III) antibody of antigen testing or records containing HIV, HIV virus or any AIDS-related conditions which may be contained in the above reference request.

Date \_\_\_\_\_ SIGNATURE \_\_\_\_\_