LOWELL
TREATMENT CENTER
WESTWOOD PEMBROKE HEALTH SYSTEM
A Division Of Arbour Health System

391 Varnum Avenue, Lowell, MA 01854 Phone 978-703-2200
Fax Completed Form to 781-762-0550

AUTHORIZATION TO OBTAIN/RELEASE
PSYCHIATRIC/SUBSTANCE ABUSE INFORMATION

Patient _____ Date of Birth _____ Phone _____

Patient Address _____

I hereby authorize:

Lowell Treatment Center ____ 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 _____