



**PEMBROKE
HOSPITAL**

WESTWOOD PEMBROKE HEALTH SYSTEM
A Division Of Arbour Health System

199 Oak Street, Pembroke, MA 02359 Phone 781-829-7000
Fax Completed Form to 781-829-7306

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

Patient _____ Date of Birth _____ Phone _____

Patient Address _____

I hereby authorize:

Pembroke Hospital ____ 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 _____