HOSPITAL *for* BEHAVIORAL MEDICINE

AUTHORIZATION TO DISCLOSE / OBTAIN INFORMATION

1. I authorize _____ to: ☐ Disclose ☐ Obtain ☐ Disclose and Obtain
   Hospital / Agency / Individual

2. ☐ Discharge Summary ☐ Discharge Staffing ☐ Psychiatric Evaluation ☐ Social History
   ☐ History and Physical ☐ Treatment / HAB Plans ☐ Physicians Orders ☐ Progress Notes
   ☐ Behavioral Plans ☐ Consultations ☐ Lab/X-Ray ☐ Photos
   ☐ Record Abstract ☐ Patient Review ☐ Medication Administration Records
   ☐ Assessments: _____ (*specify type*) ☐ Other: _____

   Concerning the care of the below named person from Date or (Range of Dates): _____

3. About (Name): _____ Social Security Number: _____
   Date of Birth: _____ Alias: _____

4. For purposes of: ☐ Personal Use ☐ Continuity of Care ☐ Placement Transfer ☐ Financial / Benefits
   ☐ Attorney ☐ State Law / Court ☐ Death ☐ Other: _____

5. Information may be disclosed / obtained: Mail, In-Person, Phone, E-Mail or by Fax (For Urgent/Emergency Needs).

   Restrictions if any: _____

6. ☐ Disclose to: /Obtain from
   Hospital for Behavioral Medicine
   100 Century Drive
   Worchester, MA 01606

   ☐ Obtain from: (Name, Address, City, State, Zip, Phone) Disclose to:
   _____
   _____
   _____

7. This authorization is valid one year from: _____

8. I understand that the above-named agency/facility/person authorized to receive this information has the right to inspect and copy the information disclosed. I further understand that if the entity receiving this information is not a healthcare provider / plan covered by HIPAA privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA regulations.

9. I understand that I may revoke this authorization; however, the revocation must be in writing and must be sent/given to the facility record's department. I understand that no revocation of this authorization shall be effective to prevent disclosure of records and communications until it is received by the person otherwise authorized to disclose records and communications.

10. Refusal to sign this form will result in the following consequences: INFORMATION WILL NOT BE DISCLOSED / OBTAINED.

11. It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation/treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDs unless specifically checked below for exclusion.
    ☐ Mental Health ☐ Developmental Disabilities ☐ Alcohol / Substance Abuse
    ☐ HIV/AIDs ☐ Other: _____

12. _____ _____ _____
    Signature of Individual (age 12 or older) Date Time

13. _____ _____ _____
    Signature of Guardian (Under 18 or Disabled) Date Time

14. _____ _____ _____
    Signature of Witness or (2nd parent/guardian, if co-custodial, may sign here) Date Time

15. _____ _____ _____
    Signature of staff person disclosing/obtaining information Date Time

Specific information about disclosures and dates shall be documented in the individual's clinical record or Disclosure Tracking System A facsimile of this original shall have the same force and effect as the original.

The Standards for Privacy of Personally Identifiable Health Information, 45 CFR parts 160 and 164, states that information used or disclosed pursuant to this authorization may be subject to a re-disclosure by the recipient of the information. The federal confidentiality Rules 42 CFR Part 2 prohibit making any further disclosure of drug or alcohol information unless further disclosure of this information is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 1. A general authorization for the release of medical or other information DOES NOT restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient (52FR21809, June 9, 1987, 52 FR2 1997, November 2, 1987)

NOTE: Your refusal to sign an Authorization to Disclose / Obtain Information will not prevent treatment, payment or enrollment in a health plan or eligibility for benefits.

DOB: HSV:
AGE: SEX:
ADMIT: RM/BED: /
ATT: #:
MR #: PAT #:

INSTRUCTIONS: Authorizations to Disclose/Obtain Information

1. Identify whether the form will be used to disclose, to obtain or to disclose/obtain (share) information and whom you are authorizing to perform this function.

2. Check the specific information you wish to disclose/obtain. Check only what is the minimum necessary to fulfill the purpose of disclosure. Enter a service date – if unknown, indicate "last service date" and only checked information from last service dates will be released or obtained.

3. Complete the individual's name, date of birth, social security number and aliases or a maiden name to help correctly identify the individual.

4. Check the purpose or reason why the information needs to be disclosed/obtained.

5. Circle all manners which the information may be disclosed/obtained. If you wish to restrict any of these, please specify. If nothing is specified, all manners of release will be considered authorized. (Information will only be faxed if URGENT.)

6. Complete the name and address of the agency, facility or person to whom you will disclose the information or complete the name and address of the agency, facility or person from whom you are obtaining the information. If you wish it to be phones or faxed, include area code and numbers.

7. Complete the calendar date (month, day, and year) on which this authorization will expire. Information cannot be disclosed/obtained without a specific date of expiration.

8. Self-explanatory.

9. Self-explanatory.

10. Self-explanatory.

11. Sensitive information will be released/obtained unless you specifically check an exclusion. **If no items are checked all information within the patient record is subject to disclosure.**

    NOTE: In accordance with federal and state privacy laws only the following person shall be entitled to consent in writing to the inspection, copying and/or the release of the individual's protected health information.
    - The individual if they are 12 years of age or older.
    - The parent or guardian of an individual less than 12 years of age **(if both parents have co-custody, both individuals must sign – on one line 13, the other on line 14.)**
    - The parent or guardian of an individual between the ages of 12 and 17, provided the individual does not object and has signed the authorization.
    - The guardian of a person 18 years of age or older.
    - An attorney or guardian ad litem who represents a minor 12 or older provided the court has entered an order granting this right.

12. Individual to sign and date here if – age 12 or older.

13. Parent to sign and date here if:
    - Individual is less than 12 years of age or
    - If individual is between 12 and 18and has signed on line 12 or Guardian to sign here if:
    - If individual is 18 years of age or older but is legally disabled. **You must provide a copy of the Guardianship court order granting you this right.**

    Guardian to sign here if:
    - If you are a guardian ad litem or attorney representing a minor 12 or older in any judicial or administrative proceeding. You must provide a copy of the court order granting you this right.

14. Witness to sign and date here. All authorizations require a witness signature to attest to the identity of the person entitled to give consent (person signing line 12/13) **Line may be used by a co-custodial parent.**

15. Staff person disclosing/obtaining information signs here. Specific dates when disclosed/obtained shall be documented in the individual's clinical record and/or the Disclosure Tracking System.

DOB: HSV:
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MR #: #:
PAT #: