NEW ENGLAND CENTER FOR MENTAL HEALTH

Authorization to release / request information
(please print clearly)
Therapist/Counselor

NECMH recognizes the patient's right to confidentiality of protected health information as set forth in federal and Massachusetts state law. You should be aware of these guidelines when requesting medical records. NECMH does not fax records. This form must be completed in its entirety and signed by the patient or patient's personal representative to be a valid authorization.

Anyone other than the patient who signs this authorization for release of records must state his or her relationship to the patient and may need to provide proof of legal authority to access the records.

PATIENT INFORMATION

Patient last name _____ First name _____ MI ____

Patient address _____
Street City State Zip

Patient e-mail _____ Patient primary phone _____

Date of birth _____ Treatment dates _____

RECIPIENT AUTHORIZATION

I, _____, do hereby authorize: New England Center for Mental Health to release a copy of my mental health information to:

THERAPIST/COUNSELOR: _____
ADDRESS: _____
PHONE: _____ to release a copy of my mental health information to:
New England Center for Mental Health 119 Russell Street, Suite 30, Littleton, MA 01420
Phone: 978 679-1200 Fax: 978 486-4037

INFORMATION TO BE RELEASED (Note: requests for release of psychotherapy notes cannot be combined with any other type of request.)

□ **Verbal communication only** regarding _____
□ Visit note(s): _____ _____
Specific topic or visit date(s) Specific provider or visit date(s)
□ My entire mental health record
□ Only those portions pertaining to: _____
Specific provider name and/or dates of treatment

PURPOSE OF INFORMATION RELEASE

□ Further mental health care
□ Vocational rehab, evaluation
□ Legal investigation
□ Disability determination
□ Insurance application
□ At the request of the individual
□ Other (specify): _____

INCLUSION OF PRIVILEGED INFORMATION

I understand that if my record contains information concerning alcohol or drug abuse/treatment that is protected by federal regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 §70, I have the option to specifically authorize the release of such information. I will initial below the information which I authorize to be released. I will write N/A (not applicable) if not applicable. If I do not initial certain information, it may not be released.

____ Substance Abuse (drug/alcohol) Treatment
____ Information related to sexually transmitted disease(s)
____ Genetic Testing
____ Communications between me, my psychiatrist, psychologist, or other behavior health professional
____ HIV, AIDS or ARC Information
____ Abortion consents/records or family planning services
____ Sexual Assault Treatment
____ Mammography records
____ Information regarding treatment and diagnosis, if I am an emancipated minor (except to my parents)

PATIENT RIGHTS AND PRIVACY

(1) I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. However, if my treatment at NECMH is for the sole purpose of creating medical information for disclosure to the recipient identified in this Authorization, NECMH may refuse to treat me if I do not sign this authorization.

(2) I understand that I may revoke this authorization by providing a written statement to NECMH, except to the extent that NECMH has already completed action on it prior to my revocation.

(3) I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release NECMH from all legal responsibilities and liabilities that may arise from the release of such protected health information.

(4) Unless otherwise revoked, I understand this authorization will remain in effect from the date of this Authorization and will expire on the following date _____, or within one year if no date is inserted.

Patient or Representative Signature: _____

Patient Name: _____

Representative Name: _____

Date: _____

If Representative, Description of Authority _____

Updated 9/11/13