NEW ENGLAND CENTER
FOR MENTAL HEALTH

Exceptional People, Extraordinary Care, Easy Access

Patients, Parents/Guardians:

Attached is a release of medical records form that you requested. Please complete the first page and sign the second page.

Please allow the office 72 hours to process your request of records.

- If you would like the complete medical record copied, check all boxes next to the **Information Requested.**
- Under the **Recipient** section please place a name and address that you would like us to send the medical records to. This can include your home address or a new physician's office only.
- Under items listed 1 through 10, please place your initials if applicable. If these do not apply, then write N/A for not applicable.
- The second page requires a signature. If the patient is 18 years or older, then they must sign the form under **Signature of Patient**. If the patient is under the age of 18, then the parent/guardian must sign under the **Signature of Personal Representative.**
- There is a $20.00 processing fee per record release. Any form of payment is accepted.

If you have any questions regarding this form or the release of medical records, please contact our office.

Thank you,

New England Center for Mental Health

$20.00 FEE COLLECTED _____

NEW ENGLAND CENTER for MENTAL HEALTH

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Please fill this form out in its entirety, sign and date

Patient Name: _____
Last First Middle

Home Address: _____

Home Telephone: _____ **Date of Birth**: _____

INFORMATION REQUESTED: ____History/Physical/Progress Notes ____Lab/X-ray reports

____Specialist's Correspondence ____Immunizations

RECIPIENT: to whom, NECMH may disclose my health information: _____

Address to where my health information should be delivered: _____

_____

TERM: This Authorization will remain in effect for 90 days, or until: _____

REASON FOR TRANSFER: _____

Please initial below if applicable (write N/A if not applicable)

1. ____ I specifically authorize release of sensitive information concerning documentation or analysis of any communication between me and my psychiatrist, psychologist, social worker, psychiatrist's nurse, mental health specialist, sex abuse counselor, domestic abuse counselor or other allied mental health or human services professional.
2. ____ I specifically authorize release of my HIV/SIDS sensitive information including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative.
3. ____ I specifically authorize release of information about drug or alcohol abuse or treatment for substance abuse.
4. ____ I specifically authorize release of information about genetic testing.
5. ____ I specifically authorize release of information about venereal disease(s).
6. ____ I specifically authorize release of information about abortion consent form(s).
7. ____ I specifically authorize release of mammography records.
8. ____ I specifically authorize release of information about family planning services.
9. ____ I specifically authorize release of information about research involving controlled substances.
10. ____ If I am an emancipated minor, I specifically authorize the release of information about my treatment and diagnosis (except to my parents)

$20.00 FEE COLLECTED _____

I understand that this Authorization will remain in effect until this Authorization expires, or I provide a written notice of revocation to New England Center for Mental Health. The revocation will be effective immediately upon New England Center for Mental Health's receipt of my written notice, except that the revocation will not have any effect on any action taken by New England Center for Mental Health before it received my written notice of revocation. I understand that federal privacy law may no longer protect the information furnished after it is released.

I understand that I may refuse to sign or revoke (at any time) this Authorization for any reason, and that such refusal or revocation will not affect the commencement, continuation, or quality of New England Center for Mental Health's treatment of me; except, however, if my treatment at New England Center for Mental Health is for the sole purpose of creating medical information for disclosure to the recipient identified in this Authorization. In that case, New England Center for Mental Health may refuse to treat me if I do not sign this Authorization.

I hereby release New England Center for Mental Health from all legal responsibility or liability that may arise from the release of this information or redisclosure by the recipient(s).

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Practice to use and/or disclose my health information in the manner described above.

_____ _____

Signature of Patient Date

If the patient is an unemancipated minor or is otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____ _____

Signature if Personal Representative | Description of Authority | Date