New England Center for Healthy Minds
289 Great Rd. Suite G1, Acton, MA 01720 ● (978) 679-1200 ● fax : (978) 486-4037

AUTHORIZATION TO RELEASE/EXCHANGE PROTECTED HEALTH INFORMATION

Patient's Name: ____ Date of Birth: ____________________

Previous Name, if any: ____ Social Security #: _________________

I request and authorize the **New England Center for Healthy Minds** to exchange healthcare information of the patient named above with:

Name: ____

Address: ____

City: ____ State: ________________ Zip:_______________________

Phone Number: __________________________________ Fax Number: _____________________________________

This request and authorization applies to:

☐ Verbal/Telephone Communication ☐ Written Summary of Treatment ☐ Transfer of Medical Records

☐ Healthcare information related to the following treatment, condition or dates: _____________________________________

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☐ Other: ____

Purpose: ☐ At individual's request ☐ Other: ____

Authorization re: sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that I permit information of this type, if it exists, to be released. I understand that if I do not check the box, the New England Center for Healthy Minds will **NOT** release such information about me if it exists.

☐ HIV/AIDS

☐ Genetic Information

☐ Mental Health ☐ Psychotherapy Notes

☐ Sexually Transmitted Diseases

☐ Treatment for Alcohol and/or Drug Abuse

- I understand that:
  - This authorization will expire one (1) year from the date signed below
  - I may revoke this authorization by notifying the New England Center for Healthy Minds but that any previously disclosed information would not be subject to such revocation
  - I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or my eligibility for benefits, unless otherwise described in the space provided here: ____
  - There is a potential for the information disclosed to be subject to re-disclosure by the recipient if the recipient is not required by law to protect its privacy

Patient Signature: ____ Date Signed: ____________________

Personal Representative Signature: ____ Authority: ______________________