

Hometown Mental Health Services, PLLC
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Authorization for Release of Protected Health Information

This form must be completed in its entirety and signed by the client or personal representative to be a valid authorization. Incorrect or incomplete forms will not be processed. Anyone other than the client who signs this authorization for release of records must state his or her relationship to the client and provide proof of legal authority to release the records.

1. CLIENT INFORMATION

Last name _____ First name _____ MI _____
Date of birth _____
Address _____
City _____ State _____ Zip Code _____
E-mail _____ Primary Phone _____

2. RECIPIENT AUTHORIZATION

I, _____ do hereby authorize _____
to release a copy of my mental health record or verbal information to person or facility below.
Name of person or facility to receive medical information:

Phone _____
Address _____

3. INFORMATION TO BE RELEASED

- Verbal communication only regarding _____
 Visit note(s) regarding: (Specific topic or visit date(s)) _____

 My entire mental health record
 Only those portions pertaining to: _____

4. PURPOSE OF INFORMATION RELEASE

Further mental health care Payment of insurance claim Legal investigation Applying for insurance
 Vocational rehab, evaluation Disability determination At the request of the individual
 Other (specify): _____

5. 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, such information will be included in this disclosure. If you **do not** wish to have released any of the categories of information described in

the paragraph above, please specify _____

6. CLIENT RIGHTS AND PRIVACY • I understand that I do not have to sign the authorization in order to receive treatment. I understand that I may revoke this authorization by providing a written statement to Hometown Mental Health Services, PLLC. • 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 Hometown Mental Health Services, PLLC from all legal responsibilities and liabilities that may arise from the release of such protected health information. • I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of 12 months, and it automatically expires 12 months after the date this form is executed.

7. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

Client Name _____

Client Signature _____ Date _____

Guardian Name (If applicable) _____

Guardian Signature (if applicable) _____ Date _____

indicate your relationship to the client and/or reason and legal authority for signing:

Client is: minor incompetent disabled deceased

Legal authority: parent legal guardian representative of deceased