ARBOUR-HRI
HOSPITAL
A Division Of Arbour Health System

227 Babcock Street, Brookline, MA 02446 Phone 617-731-3200
Fax Completed Form to 617-232-4914

AUTHORIZATION TO OBTAIN/RELEASE
PSYCHIATRIC/SUBSTANCE ABUSE INFORMATION

Patient ____ Date of Birth _______________ Phone _______________________

Patient Address ____

I hereby authorize:

Arbour-HRI Hospital ____ or Arbour Counseling Services, Brookline (*formerly The Commonwealth Center*) ____

To: (check one) Obtain from ____ or Release to ____

Facility____ Address ___________________________________

Attention____Fax # (if applicable) ___________________________

The following information contained in the medical/psychiatric/substance abuse record of the above named patient pertaining to services provided on or about ____

Please check the appropriate information to be released:

Admission Note____ Discharge Summary____ Consults ____ Treatment Plan ____ Physical Examination ____

Psychological Tests____ Lab Work ____ Other (be specific) ____

The information is needed for the following purpose(s) and may not be re-disclosed:

To provide ongoing treatment/aftercare: ____

Other: ____

Please check the appropriate statements:

I DO____ I DO NOT____ CFR Part H. authorize disclosure of information which refers to treatment or diagnosis of drug or substance abuse which I understand is protected by Federal Regulation: 42

I agree ____ that a copy of this form is valid as the original.

I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of information and /or psychiatric records including Alcohol and Drug Abuse information, if applicable, about my condition and treatment to those persons/agencies named above, provided a release of information is done substantially in accordance with applicable laws. I understand this consent is subject to revocation at any time unless action based on it has already begun. The authorization expires 90 days from the date of ________________

This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated thereunder. Once the requested PHI is disclosed, the Privacy Regulations may no longer protect it, if the PHI's recipient re-discloses it.

My records may ____ may not be ____ faxed. Please initial _______________

Date________________ PATIENT SIGNATURE ____

Date________________ WITNESS SIGNATURE ____

SIGNATURE OF LEGAL GUARDIAN OR PARENT of patient under 18 ____

Relationship to patient ____

Date________________ ADOLESCENT SIGNATURE ____

Authorization to Release HIV Information

I hereby specifically authorize the release of HIV (HTLV III) antibody of antigen testing or records containing HIV, HIV virus or any AIDS-related conditions which may be contained in the above reference request.

Date________________ SIGNATURE ____