BOURNEWOOD HEALTH SYSTEMS
AUTHORIZATION TO RELEASE INFORMATION

Addressograph Stamp

I, _____, authorize and request
Name of Patient
Bournewood Health Systems, 300 South St., Brookline, MA 02467 to release or obtain the following information to/from:

OTHER	**OTHER**
Organization:	**Organization:**
Name:	**Name:**
Street:	**Street:**
City / State:	**City:**
Phone:	**Phone:**
Release **Obtain**	**Release** **Obtain**
☐ **Check Box If Discharge Summary Needs To Be Sent After Discharge** ☐	☐ **Check Box If Discharge Summary Needs To Be Sent After Discharge** ☐
☐ Verbal/telephone/**fax/send** communication RE: Content of entire medical record or any portion thereof ☐	☐ Verbal/telephone/**fax/send** communication RE: Content of entire medical record or any portion thereof ☐
☐ Presence in Treatment Letter	☐ Presence in Treatment Letter
☐ Other ☐	☐ Other ☐
	☐ Discharge Instructions and Orders Form **ONLY**

For the Purpose of: ☐ Evaluation ☐ Discharge Planning ☐ Treatment Planning
☐ Legal Matter (Specify) ☐ Other

THE TREATMENT DATES COVERED BY THIS AUTHORIZATION ARE FROM _____TO_____.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Director of Medical Records.

I understand that the information, which I am authorizing to be released, may contain drug/alcohol information, and is protected by Federal Regulation 42CFR.Part II. Such information may not be released without my written consent unless release is specifically provided for in the Federal Regulations. I authorize the release of all HIV and HIV / STD related information protected under Federal Law. I understand that I have the right to refuse release of the information.

_____
(DATE) **(PATIENT'S SIGNATURE)** **(DATE OF BIRTH)**

_____
(DATE) **(LEGAL GUARDIAN'S SIGNATURE, If Applicable)** **(RELATIONSHIP TO PATIENT)**

_____
(DATE) **(WITNESS)**