

I, _____ (Patient Name & Date of Birth) hereby authorize Bournewood Health Systems, 300 South St., Brookline, MA 02467 to release and/or share the following information concerning me:

TO:

Name (Individual and/or Organization Entity): _____

Address: _____

FAX #: _____ Telephone #: _____

Other contact information (e.g., email/contact person, if applicable): _____

For the purpose(s) of: Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: "at my request" if you are initiating the request.

The information authorized to be disclosed/requested by this authorization is:

All protected health information in my Medical Records and Billing Records; **OR** Billing Records

OR All Medical Records (excluding Billing Records); **OR** Discharge Summary Report (includes Psychiatric Evaluation, Discharge Summary, Discharge Instructions, Medication List) **OR**

Describe the information that may be disclosed:

Covering the period of care from:

Latest visit **OR** All dates of encounters/visits **OR** Specific date(s): _____ to _____

I agree that the following information if present in my record may be released (please check all that apply):

Substance Use Disorder treatment records Genetic screening test results Communicable Diseases

Confidential communications with mental health professionals (including counselors and social workers)

HIV/AIDS test results and related information Sexually Transmitted Infections/Sexually Transmitted Diseases

Expiration Date: This authorization will expire on the following date, event, or condition: _____

If none is indicated, this authorization will remain in effect until such time as the patient revokes such consent in writing.

By signing below, I indicate my understanding to the following:

- I have the right to refuse to sign this authorization. Bournewood will not condition the provision of treatment to you or your eligibility for benefits on whether or not you sign this authorization.
- I have the right to revoke this authorization at any time by submitting a written request to Bournewood Health Information Services at 300 South St., Brookline, MA 02467. Such revocation will be effective as of the date of receipt. I understand that if I revoke this authorization the revocation will not apply to information that has already been released or actions that have already been taken in reliance on this authorization, including requests from my insurer to contest a claim under my policy.
- I understand that once my 42 C.F.R., Part 2 information is disclosed by Bournewood in reliance on this authorization, the records may be subject to redisclosure by the recipient and no longer protected by 42 C.F.R., Part 2.

YOU HAVE A RIGHT TO RECEIVE A SIGNED COPY OF THIS AUTHORIZATION, UPON REQUEST.

Patient/Authorized Representative Signature* _____ Date: _____

Printed Name of Authorized Representative: _____

Relationship to Patient: _____

*If signed by a patient-authorized representative, supporting legal documentation of authority must accompany this form.