Hometown Mental Health Services, PLLC
Phone:413-343-4175
Fax:413-371-8098

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