ELIOT COMMUNITY HUMAN SERVICES, INC.
AUTHORIZATION FOR THE USE OR DISCLOSURE OF INFORMATION

Client Name: _____ **Date of Birth:** _____

I hereby authorize Eliot Community Human Services to: (SELECT) Obtain From: ✓ Release To: ✓

Facility or Individual: Mass. Dept of Mental Health

Address: 35 Nagog Park, 2nd Floor, Acton, MA 01720
Street City State Zip code

Attention: Roberta Glynn (Fax #) _____ (Phone) 978-206-2120
Name

INFORMATION TO BE RELEASED

Information contained in the record for the individual named above regarding services provided for the period From current To _____ (Initial information you authorize to be released below)

_____ Admission Intake Documents
_____ Psychopharmacology Evaluations Medication Information
_____ Medical Exams and Treatment Medical Consultations Lab Results
_____ Assessments Clinical Evaluations & Treatment Recommendations
X Diagnosis & Treatment Plans
_____ Discharge Plans and Summaries
_____ Other: _____

INFORMATION TO BE RELEASED FOR THE FOLLOWING PURPOSE(S)

X To help determine eligibility for treatment services by a state agency
_____ At the request of your insurance company
_____ Coordination of services/treatment
_____ Sending information to a laboratory (for purposes of testing)
_____ Other: _____

I do hereby release Eliot Community Human Services, Inc. and or other agencies or persons named above from all liability and all claims pertaining to the disclosure of this information.

Please Initial One:

_____ I wish to review the information listed above before release X I do not wish to review the information before release.

This authorization demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA). Standards of Privacy for Individually Identifiable Health Information (PHI). 45 CFR 160 and 164 and all regulations and interpretive guidelines promulgated there under. I understand that federal privacy laws may no longer protect my PHI once it has been released and that my PHI may be redisclosed by the recipient. I understand that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that I have a right to receive a copy of this form after I have signed it.

I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by Eliot Community Human Services prior to receipt of my written notice of revocation. I further understand that I must provide any notice of revocation in writing. I may revoke this authorization by writing to Eliot Community Human Services, ATT: Compliance Officer at 186 Bedford Street, Lexington MA 02420. **This authorization will automatically expire in one (1) year from the date it is signed.**

X _____	x _____	_____	3/1/17
Client/Guardian Signature	Date	Staff Member Signature	Date
_____	_____	_____	_____
Revocation Signature Client Guardian	Date	Staff Member Signature	Date