

## Consent / Authorization to Disclose Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

- I authorize the use or disclosure of the above-named individual's health information as described below.
- The following individual or organization is authorized to make the disclosure:  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> Admission Consultation Note	<input type="checkbox"/> Summation of Hospitalization
<input type="checkbox"/> Therapist's Initial Contact Note/Monthly Progress Notes	<input type="checkbox"/> Medical History & Physical Examination
<input type="checkbox"/> Comprehensive Psychopharmacology Evaluation Note	<input type="checkbox"/> Laboratory Reports _____
<input type="checkbox"/> Monthly Medication Notes	<input type="checkbox"/> Entire Record (including all of the above )
<input type="checkbox"/> Case Abstract _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Psychological Test Report	
- The following specially protected health information may be disclosed: (please initial)  
\_\_\_\_\_ (initials) **HIV / AIDS:** I authorize the disclosure of protected health information pertaining to HIV testing and/or diagnosis (including the results of an HIV antibody or antigen test or medical records containing such information) and/or treatment related to Acquired Immune Deficiency Syndrome (AIDS) to the person or organization named below and for the purpose stated below.  
\_\_\_\_\_ (initials) **Drug and Alcohol Abuse and Treatment:** I authorize the disclosure of records of a federally assisted drug and alcohol treatment program to the person or organization named below and for the purpose stated below. I understand that these alcohol and drug treatment records are protected under federal regulations. I also understand that these alcohol and drug treatment records cannot be re-disclosed without my express authorization.
- This information may be disclosed to and used by the following individual or organization (the "Recipient"):  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
for the purpose of: \_\_\_\_\_
- I understand that I have a right to revoke this consent/authorization at any time. I understand that if I revoke this consent/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 consent/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 consent/authorization will expire 12 months from the date below.
- I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this consent/authorization. I understand that generally the person(s) and/or organization listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this consent/authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact the medical records department or the privacy officer of the Austen Riggs Center. If I sign this authorization, I must be provided with a signed copy of the form if I so request.
- I hereby release the authorized person, the Austen Riggs Center, and the officers, directors and employees of the Austen Riggs Center from any and all legal responsibility or liability for the disclosure to the Recipient of the information covered by this consent/authorization.
- I agree that a photocopy of this signed consent/authorization may be accepted with the same authority as the original.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Signature of Witness