PATIENT LABEL

TARAVISTA
BEHAVIORAL HEALTH CENTER
85 Patton Road; Devens, MA 01434
Phone: 978.615.5200; Fax: 978.243.9584

Authorization for Use/Disclosure of Protected Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

(Patient/Client/Resident Name)_ (Facility/Program) (Date of Birth)

I hereby authorize TaraVista Behavioral Health Center to **release** information contained in my record to the following individual or organization: _____

Address City State Zip Code Phone Number Fax

I hereby authorize TaraVista Behavioral Health Center to **obtain** information contained in my record to the following individual or organization: _____

Address City State Zip Code Phone Number Fax

This information is being disclosed for the purpose of: _____

This information is being disclosed by (if applicable): _____

INFORMATION TO BE OBTAINED OR DISCLOSED: (Patient should check all that apply)

Covering the period of health care from _____ to_____

- ☐ Discharge Summary
- ☐ History and Physical Examination
- ☐ Consultation Reports
- ☐ Immunization
- ☐ Laboratory Tests
- ☐ Cardiology Reports (EKGs, Echos, etc.)
- ☐ X-ray reports
- ☐ Operative/Procedure Reports
- ☐ Assessments
- ☐ Psychiatric/Psychosocial Evaluation
- ☐ Medication Evaluation
- ☐ Pathology Reports
- ☐ Emergency Room Record
- ☐ Other _____
- ☐ Communication
- ☐ Treatment Plan
- ☐ Complete Health Records, excluding all images (x-ray, photographs, etc)

STATUTORILY PROTECTED RECORD: (Patient should check & initial all that apply)

- ☐ HIV/AIDS diagnosis/treatment/test results_____
- ☐ Behavioral/Mental Health_____
- ☐ Alcohol/Drug Abuse_____
- ☐ Sexually Transmitted Diseases_____
- ☐ Domestic Violence Counseling _____
- ☐ Sexual Assault Counseling_____
- ☐ Psychotherapy Notes _____
- ☐ Other _____

I understand that I have the right to revoke this authorization at any time. This does not apply to information that has already been released prior to receiving the revocation.

If not previously revoked, this authorization will expire on_____, or after 90 days unless otherwise specified (not to exceed 1 year).
TaraVista Behavioral Health Center, it's employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Prohibition of Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person it pertains, or as otherwise permitted by such regulations. A general authorization for the release of Medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION BUT RECORDS CANNOT BE RELEASED WITHOUT YOUR SIGNATURE

_____ _____
Patient/Client/Resident's Signature Date/Time

_____ _____
Parent/Guardian's/Empowered Representative Signature Date/Time

_____ _____
(Print Name) Parent/Guardian's/Empowered Representative Relationship

_____ _____
Witness Date/Time