Behavioral Health Affiliates, LLC

84 High Street, Suite 2A · Medford, MA 02155 · 781-393-0009 · 781-395-2909 fax

RELEASE OF TREATMENT INFORMATION

I, ________________________________, whose Date of Birth is _____/____/_____, authorize Behavioral Health Affiliates, LLC

to disclose to and/or obtain from:____ the following information:

Description of Information to be Disclosed (Patient/Client should ***initial*** each item to be disclosed)

______ Assessment
______ Diagnosis
______ Psychosocial Evaluation
______ Psychological Evaluation
______ Psychiatric Evaluation
______ Treatment Plan or Summary
______ Current Treatment Update
______ Medication Management Information
______ Nursing/Medical Information
______ Toxicological Reports/Drug Screens
______ Educational Information
______ Discharge/Transfer Summary
______ Presence/Participation in Treatment
______ Progress in Treatment
______ Other____________________________
______ Other____________________________

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
If other purpose, please specify: ____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Behavioral Health Affiliates, LLC. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires as of the termination of treatment or as otherwise indicated: ________________________

Conditions

I further understand that Behavioral Health Affiliates, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may compromise my treatment.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format or electronically.

I will be given a copy of this authorization for my records, if requested.

______ Check here if patient/client refuses to sign authorization

____ _____/_____/_____
Signature of Patient/Client Date

____ _____/_____/_____
Signature of Parent/ Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.) ____

____ _____/_____/_____
Signature of Staff Witness Date