NEWTON-WELLESLEY PSYCHIATRY

40 Walnut Street, Suite 302, Wellesley, MA 02481
TEL: 617-332-2047 FAX: 617-332-7341

Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I, _____ (date of birth ___/___/_____)

hereby authorize the exchange of my private healthcare information between

_____ of Newton-Wellesley Psychiatry and

Person/Title _____

Location/Facility _____

_____

Telephone Contact Number _____ Fax Number _____

Purpose *(Check the appropriate box and include a short description when necessary):*

- ☐ At the Request of the Individual _____
- ☐ Medical Care _____
- ☐ Legal Matter _____
- ☐ Insurance _____
- ☐ Other *(please specify)* _____

INFORMATION TO BE RELEASED (please check all that apply):

- ☐ Admission/Discharge Note
- ☐ History
- ☐ Information to Coordinate Care
- ☐ Other (specify)_____
  _____

Individual or Individual's Personal Representative MUST read and initial the following statements.

1. I understand that Newton-Wellesley Psychiatry will not condition my treatment, (and applicable payment for my health care, my enrollment in a health plan or eligibility for benefits) on whether I provide authorization for the requested use and disclosure – except in limited circumstances (e.g., if the treatment is research-related or the treatment is necessary for the purpose of creating protected health information for disclosure to a third party such as physical examinations for school, camp, or employment purposes).

   INITIALS: _____

2. I understand that I have a right to revoke this authorization at any time. My revocation must be in a written letter addressed to Tracey Young, Operations Manager. I understand that such revocation does not affect any action taken by Newton-Wellesley Psychiatry before Newton-Wellesley Psychiatry received my written notice.

   INITIALS: _____

3. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

   INITIALS: _____

4. I understand that I may see a copy of the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it.

   INITIALS: _____

5. I understand that this authorization expires on: _____ **or,** _____
   (Identify Date (Month, Day, Year)) (Identify Expiration Event)

   INITIALS: _____

6. I understand that this authorization is voluntary and I have the right to refuse to sign this authorization.

   INITIALS: _____

Form must be completed before signing

_____ _____
Signature of Individual or Personal Representative of Individual Date

Print Name of Individual: _____

Printed Name of Personal Representative: _____

Relationship of Personal Representative to Individual: _____