

UNIVERSITY OF MASSACHUSETTS
University Health Services - Mental Health Division
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Amherst, MA 01003-9328
(413) 545-2337; Fax (413) 545-9602

AUTHORIZATION FOR RELEASE OF INFORMATION

This form when completed and signed by you, authorizes release of protected information from your clinical record to the person you designate.

NAME: _____ DOB: _____ PHONE: _____

ADDRESS: _____

I authorize: _____
(Name of Provider/Facility) (Address)

to release *(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)*

Release information to: _____

I am requesting that this protected information be released for the following reasons: ("at the request of the individual" is all that is required if you do not desire to state a specific purpose.)

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure).

If the box to the left is marked, I also give my permission for the release of information regarding assessment, diagnosis, and treatment of alcohol and/or substance abuse.

If the box to the left is marked, I also give my permission for the release of information relating to confidential information and diagnosis and/or treatment of acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or HIV status.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that action has been taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my mental health clinician generally may not condition psychological/psychiatric services upon my signing an authorization unless these services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of this information and no longer protected by the HIPAA Privacy Rule.

SIGNATURE OF PATIENT

DATE

SIGNATURE OF PARENT/GUARDIAN

DATE

SIGNATURE OF WITNESS

DATE