SNBCare
Spectrum Neuro Behavioral Care

Authorization to Disclose/Receive Healthcare Information

Name: ____________ Date of Birth: ____________

By signing below, I hereby authorize disclosure of information in the medical record of the patient identified above which includes information that may be stored in a paper and/or electronic format. Such record may contain information on demographics; financial/insurance information; general medical care; alcohol and drug abuse treatment; psychiatric treatment; behavioral or mental health treatment; HIV or AIDS; AIDS-related treatment; sexually transmitted diseases or infections; venereal disease; tuberculosis; hepatitis. Disclosure shall be limited between the listed entities and to the information obtained during the course of treatment.

○ I hereby authorize SNBCare to disclose information to the below party. ○ I hereby authorize SNBCare to obtain information from the below party.

A release form needs to be filled out for each institution and/or individual you would like information obtained from and/or send to. If you have been recently hospitalized, please ensure you complete a consent to release with that facility's information.

Please provide the information of who you are authorizing below. This can be your PCP/therapist/hospital/an individual/etc. Without their information, this release is not valid.

Spectrum Neuro Behavioral Care

Tel: 781-666-2711 | Fax: 781-666-2712

Name: ____________

Address: ____________

Telephone: ____________

Fax: ____________

The following information is requested or to be released: [To be completed by staff]

☒ Psychiatric evaluation/Mental status ☒ History & Physical ☒ Referral Information ☐ Medical Consultation ☒ Laboratory/Pathology results ☒ Discharge summary/instructions ☒ Psychological test results ☒ Treatment Plan ☒ Neurological test results ☒ Progress notes ☐ Financial account information

☐ Other: ____________

For the purpose of disclosure:

☒ Medical care ☐ Insurance/payment ☐ Legal matters ☐ Vocational purposes ☒ Coordination of care ☐ Referral purposes ☐ Family involvement

☐ Other: ____________

State and federal law protects the following information. If this information applies to you, please initial to authorize Sign for release of such specifically protected or privileged information:

☐ Alcohol and/ or substance abuse record ☐ Domestic violence counseling ☐ HIV/ AIDS testing, results and record ☐ Sexual assault counseling ☒ Mental health record ☐ Genetic testing

The dates of service being requested are from the time period treatment occurred, unless specifically limited to the dates specified as follows:

Disclosure format

Fax or paper/US mail is default if not marked. Specify email or other electronic format:

- Authorization is valid only if received within 90 days of being signed and expires within one year from date of signature or if services are terminated prior to the one year or if otherwise specified:
- I may revoke this authorization at any time by submitting a written request. Revocation will not apply to information disclosed prior to receiving notification of revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
- I have a right to request a copy of this authorization.
- I understand that I have the right to refuse this authorization and treatment will not be contingent on signing this authorization.
- I have carefully read and understand this authorization and have had any questions answered to my satisfaction. By signing below I do hereby expressly and voluntarily authorize disclosure of the above information regarding my health to the persons or agencies listed above.

Patient Signature/ Legal Representative:

Date:

Relationship to patient, if applicable: