AUTHORIZATION FORM TO OBTAIN/RELEASE INFORMATION FROM ANOTHER ENTITY

SECTION A: USE OF DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I, (client name) _____ authorize the use or disclosure of my individually-identifiable health information maintained by:

TO OBTAIN INFORMATION FROM ANOTHER ENTITY

From the Provider: _____
Print Name of Provider

Address: _____
Print Address of Provider

My health information may be disclosed under this Authorization to:

To the Recipient: **Community Counseling of Bristol County, Inc.** _____
Organization to receive the information — Print Name of Individual to receive information

Address: _____ _____
Print Address of Recipient — City, State, Zip

TO RELEASE INFORMATION FROM ANOTHER ENTITY

From the Provider: **Community Counseling of Bristol County, Inc.**

Address: _____
Print Address of Provider

My health information may be disclosed under this Authorization to:

To the Recipient: _____ _____
Organization to receive the information — Print Name of Individual to receive information

Address: _____ _____
Print Address of Recipient — City, State, Zip

Health information includes information collected from me or created by the Provider, or information received by the Provider from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I further understand that under state law the Provider is prohibited from disclosing information about my HIV status without my specific written authorization. The Provider is also prohibited under sate law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

SECTION B: SCOPE OF USE OR DISCLOSURE

Health information that may be used or disclosed through this Authorization is as follows:

Check One:

☐ All health information about me, **including** my clinical records, created or received by the Provider. This information may include, if applicable:

- Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
- Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.
- Information regarding the results of a genetic test.

☐ All health information about me as described in the preceding checkbox, excluding the following:

_____

☐ Specific health information **including only**: _____

_____

_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

Check One:

☐ Specifically, the following purposes(s): _____

_____

☐ The request for information to be used or disclosed has been initiated by the Client and the Client does not elect to disclose its purpose. *Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.*

SECTION D: EXPIRATION

This Authorization expires: _____

(Insert applicable event or date – Month, Day, Year)

Note: If an expiration event is used, the event must relate to the Client or the purpose of the use or disclosure.

SECTION E: OTHER IMPORTANT INFORMATION

1. I understand that the Provider cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from Community Counseling of Bristol County, Inc., except when I am (i) receiving research-related treatment or (ii) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.
3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Office at Community Counseling of Bristol County, Inc. The address of the Privacy Office is One Washington Street, Taunton, MA 02780.

This paragraph is only applicable to certain Authorizations to disclose health information for marketing purposes: I understand that Community Counseling of Bristol County, Inc. may, directly or indirectly, receive remuneration from a third party in connection with the marketing activities undertaken by Community Counseling of Bristol County, Inc.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's Signature:_____ Date of signature:_____

Print Client's Full Name: _____

Client's Home Address: _____

Client's Home Telephone: _____ Date of Birth: _____

When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of legal representative: _____ Date of Signature: _____

Print Name: _____

Relationship of representative to client: _____

Optional: Photo I.D.# of Signature: _____ Witness: _____

Client has been provided with a copy of the signed Authorization. _____

Initials