



**2-WAY PROVIDER COMMUNICATION
Authorization To Use Or Disclose
Protected Health Information**

I hereby authorize the exchange of my/my child's/or ward's protected health information including my/my child's/or ward's psychiatric records between Aspire Health Alliance and/or the individual/organization named below. Disclosure may be by handwritten, electronic or verbal exchange.

Client Name	Date of Birth	Medical Record Number
Address (Street, City, State, ZIP Code)		Telephone Number

This information may be exchanged with and used by the following individual or organization.

Name: _____
 Address: _____
 Telephone: _____ Fax: _____

Treatment Dates: You Must Check

- All Dates
 Specific Dates _____

Purpose of Request: You Must Check

- | | | |
|---|---|-----------------------------------|
| <input type="checkbox"/> Treatment | <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Disability | <input type="checkbox"/> Insurance | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Other Specify: _____ | | |

I authorize the disclosure of the following information which may be included in my record.

You Must Initial

- | | | |
|--|-------------------------------------|---------------|
| ____ Genetic Testing | ____ Sexually Transmitted Diseases | ____ Abortion |
| ____ HIV Information | ____ AIDS or AIDS Related Condition | |
| ____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 | | |

I authorize the disclosure of the following information from my medical record.

You Must Check

- | Yes | No | Yes | No | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge Summary | <input type="checkbox"/> | <input type="checkbox"/> | Medication Records |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment Plans | <input type="checkbox"/> | <input type="checkbox"/> | Psychological Testing Results |
| <input type="checkbox"/> | <input type="checkbox"/> | Consultations (including psychiatric evals) | <input type="checkbox"/> | <input type="checkbox"/> | Laboratory Results (including drug screenings) |
| <input type="checkbox"/> | <input type="checkbox"/> | Crisis Evaluations | <input type="checkbox"/> | <input type="checkbox"/> | History and Physical |
| <input type="checkbox"/> | <input type="checkbox"/> | Case Assessments | <input type="checkbox"/> | <input type="checkbox"/> | Physician Orders |
| <input type="checkbox"/> | <input type="checkbox"/> | Progress Notes | <input type="checkbox"/> | <input type="checkbox"/> | Complete Record |
| <input type="checkbox"/> | <input type="checkbox"/> | Billing Records | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

All checked items above, **excluding** the following: _____
(Clients Initials) _____

Disclose **only** the specific information listed: _____
(Clients Initials) _____



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This information should be sent to the attention of _____ at the address indicated below:

1501 Washington Street
Braintree, MA 02184

500 Victory Road
Quincy, MA 02171

2 Moon Island Road
Quincy, MA 02171

639 Granite Street
Braintree, MA 02184

460 Quincy Avenue
Quincy, MA 02169

215 Sandwich Road
PO Box 31
Wareham, MA 02571

769 Plain Street, Unit I
Marshfield, MA 02050

859 Willard Street
Quincy, MA 02169

South Shore Hospital (Bridge Clinic)
55 Fogg Road
Weymouth, MA

64 Industrial Park Road
Plymouth, MA 02360

12 Hancock Court
Quincy, MA 02169

Other: _____

All questions should be directed to the Medical Records Department (617) 847-1941.

OTHER IMPORTANT INFORMATION

- 1. I understand that the Provider of the information disclosed 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 consumer 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 consumer or as otherwise permitted under federal law governing Confidentiality or Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).
2. 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 before the Provider received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the Privacy Officer of Aspire Health Alliance at 500 Victory Road, Quincy, MA 02171.
3. Unless otherwise revoked, this authorization will expire on the following date, event, or condition or within one year: _____

I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

Signature of Client or Legal Guardian Date
If Signed by Legal Guardian, Relationship to Patient

Office Use Only
Information Sent: _____
Date: _____ By: _____
Original Copy to Client's medical record; copy to requester