aspire health alliance
State Designated Community Behavioral Health Center

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***

☐ Treatment ☐ Coordination of Care ☐ Personal

☐ Disability ☐ Insurance ☐ Legal

☐ 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**	
☐	☐	..... Discharge Summary	☐	☐	..... Medication Records
☐	☐	..... Treatment Plans	☐	☐	..... Psychological Testing Results
☐	☐	..... Consultations (including psychiatric evals)	☐	☐	..... Laboratory Results (including drug screenings)
☐	☐	..... Crisis Evaluations	☐	☐	..... History and Physical
☐	☐	..... Case Assessments	☐	☐	..... Physician Orders
☐	☐	..... Progress Notes	☐	☐	..... Complete Record
☐	☐	..... Billing Records	☐	☐	..... Other _____

☐ All checked items above, **excluding** the following: _____

_____ **(Clients Initials)** _____

☐ Disclose **only** the specific information listed: _____

_____ **(Clients Initials)** _____

aspire health alliance
State Designated Community Behavioral Health Center

2-WAY PROVIDER COMMUNICATION

Authorization To Use Or Disclose
Protected Health Information

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

☐ 1501 Washington Street
Braintree, MA 02184

☐ 639 Granite Street
Braintree, MA 02184

☐ 769 Plain Street, Unit I
Marshfield, MA 02050

☐ 460 Quincy Avenue
Quincy, MA 02169

☐ 2 Moon Island Road
Quincy, MA 02171

☐ South Shore Hospital (Bridge Clinic)
55 Fogg Road
Weymouth, MA 02190

☐ 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 Receipient 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 1501 Washington St., Braintree MA 02184.
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