Towerlight Health and Wellness
13 Steeple St., Ste. 202-37
Mashpee, MA - 02649-3287

Release for Two-Way Exchange of Information

Section I. PATIENT INFORMATION

Patient's Current Full Legal Name: *

Patient's Full Legal Name at Time of Care (if different):

Patient's Date of Birth: *

Patient's Full Address: *

Last 4 digits of Social Security Number (optional):

Section II. AUTHORIZATION

I hereby authorize Towerlight Health and Wellness, LLC to: *

☐ Release my records. ☐ Obtain my records.

If both options are selected, this authorization permits reciprocal exchange of information between Towerlight Health and Wellness, LLC and the parties listed below.

I request and give permission to:

Towerlight Health and Wellness LLC,
P (508) 375-7936, F (855) 631-0756,
13 Steeple St, 202-37
Mashpee, MA 02649

for disclosure of my individually-identified health information and communication with the individuals listed below.

Who may receive and disclose my information:

Full Name of Primary Care Physician or Clinic:

Site Location:

Previous Psychiatrist or Psychiatric Nurse Practitioner: _____

Site Location:

Full Name of psychiatric facility (if hospitalized in last 24 months):

Site Location:

Full Name of Psychotherapist: *

Site Location:

Full Name of any other Individual or Organization that may exchange information with provider:

Site Location:

☒ If no other providers are listed, this authorization extends to the patient's current primary care provider and any treating psychiatrist, psychotherapist, therapist, or mental-health clinician involved in the patient's care for coordination and continuity of treatment purposes only.

Section III. INFORMATION TO BE RELEASED

What information can be disclosed?

Please specify which documents or categories of records are requested from or released to the provider listed below. Only the items selected below will be requested or disclosed.

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Information may include: *

- ☐ All health information, including mental health, psychiatric, psychological, behavioral health, medication, laboratory, consultation, and progress note information (excluding psychotherapy notes unless additionally authorized below)
- ☐ Psychotherapy Notes
- ☐ Past/Present Medications
- ☐ Progress Notes
- ☐ Diagnostic Test Reports
- ☐ History/Physical Exam
- ☐ Lab Results
- ☐ Physician's Orders
- ☐ Discharge Summary
- ☐ Billing Information

Section IV. REASON FOR DISCLOSURE

Reason for disclosure:

(Choose one option) *

- ☐ Treatment/Continuing Health Care
- ☐ Billing or Claims
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ At the request of the patient

Section V. SPECIFIC AUTHORIZATION

Permission to disclose specific health information. Only if you choose to share any of the following information, please initial below.

I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV/AIDS testing, diagnosis or treatment.

☐ Yes ☐ No

I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that federal law (42 CFR Part 2) protects these records. They may not be used in civil, criminal, administrative, or legislative proceedings against me without my consent or a court order. Once I consent, HIPAA-covered entities and their business associates may redisclose this information as permitted by HIPAA.

☐ Yes ☐ No

I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

☐ Yes ☐ No

If signed by a parent or legal guardian on behalf of a minor patient: I certify that I am the parent or legal guardian of the patient and have the legal authority to authorize the release of this information on their behalf, including any information protected under M.G.L. c. 111, §70G, M.G.L. c. 111, § 70F and/or 42 CFR Part 2, as applicable.

PATIENT INITIALS: _____

These specific authorizations apply to any equivalent federal or state law protecting this information.

Section VI: PATIENT RIGHTS AND PRIVACY

I understand and agree that:

• This authorization is voluntary;

• My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;

• I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;

• My health information may be subject to re-disclosure by the recipient. If the information includes substance use disorder treatment records protected by 42 CFR Part 2, it may be redisclosed only as allowed by HIPAA or as otherwise permitted by law.

• This authorization will expire one year from the date I sign the authorization, unless I choose to authorize disclosure for treatment, payment, and healthcare operations (TPO). If I do so, the authorization will remain in effect until I revoke it in writing by notifying Towerlight Health and Wellness, LLC. Revocation will not affect any actions already taken based on this authorization before the date my revocation is received and processed.

Section VII. PATIENT/PARENT/GUARDIAN SIGNATURE

SIGNATURE: *

PRINTED NAME: *

Signer's relationship to patient ☐ Parent ☐ Guardian ☐ Other

DATE: *

Revised 02/03/26