monte nido

montenido.com

Authorization to Use or Disclose Protected Health Information

Monte Nido is hereby authorized to receive or disclose the following protected health information from the medical or psychiatric records of the patient listed below.

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: ___ / ___ / ___

Address: _____ _____ ___ ___
Street *City* *State* *Zip*

Telephone: (___) ___ – ___ Email: _____

LOCATION(S) OF CARE:

Please provide the exact program name and location for which you are requesting records.

☐ Monte Nido
Specific program(s): _____

☐ Rosewood
Specific program(s): _____

☐ Clementine
Specific program(s): _____

☐ Walden
Specific program(s): _____

☐ Other: _____
Name, location, address or physician where you received care

RELEASE RECORDS TO:

_____

METHOD OF DELIVERY:

☐ Secure Email (ShareFile) ☐ Mail ☐ Fax ☐ Other (specified) _____

PURPOSE OF THE REQUEST (CHECK ONE):

☐ Medical Care ☐ Legal Care
☐ Insurance ☐ Personal
☐ Other

FOR DATE(S) OF SERVICE:

From ___ / ___ / ___ to ___ / ___ / ___
(Dates MUST be specified)

INFORMATION TO BE DISCLOSED:

☐ Abstract of Record ☐ Laboratory Reports ☐ Any and All Records
☐ Discharge Summary ☐ Assessments ☐ Other (specified) _____
☐ History & Physical ☐ Group/Progress Notes

FORM DISCLOSURE:

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

SPECIFICALLY AUTHORIZED RELEASE OF INFORMATION *(Initial, If Applicable)*:

I understand that my health information may contain the following types of sensitive information and I expressly and voluntarily give permission to release the following:

☐ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c. 111 70F, an HIV/AIDS diagnosis or treatment. I specifically authorize disclosure of this information.

☐ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2. I specifically authorize disclosure of such information.

☐ Release Psychiatric & Mental Health/Behavioral Health Records. Psychotherapy Records will NOT be released. Release of Psychotherapy Records requires a separate release form.

☐ Release Sexually Transmitted Diseases

I UNDERSTAND THAT:

- I may refuse to sign this authorization.
- The original or a copy of this authorization shall be included with my original records.
- Unless otherwise revoked, this Authorization expires ☐ / ☐ / ☐ *(insert applicable date or event)*. If no date is indicated, the Authorization will expire 30 days after the date of signature.
- I understand that this authorization will remain in effect until the term of this authorization expires, or I provide a written notice of revocation. The revocation will go into effect immediately upon receipt, except that it will not apply to any action taken by the hospital before receipt of the written notice of revocation.
- I understand that the person receiving my Protected Health Information may not be required to comply with federal and state privacy laws, and my Protected Health Information may no longer be protected by the applicable state and federal law once it is disclosed by Monte Nido.
- I have read and understand the terms of this authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize disclosure of the above protected health information to the persons or agencies listed above.
- Additionally, I understand that treatment or payment cannot be conditioned on my signing this authorization.

_____ ☐ / ☐ / ☐

Signature of Patient or Legal Guardian *Date*

_____

Printed Name of Patient or Legal Guardian

OFFICE USE ONLY

Date Records Copied: ☐ / ☐ / ☐ Copied By: _____

Medical Copies sent via: ☐ Mail ☐ Email ☐ Fax to: _____