Beth Israel Lahey Health
Behavioral Services

ID # _____

AUTHORIZATION TO OBTAIN AND/OR RELEASE INFORMATION AND RECORDS

Client Name: _____ D.O.B. _____

I authorize Northeast Behavioral Health Corporation, d/b/a Beth Israel Lahey Health Behavioral Services, (BILH BS), to obtain and/or release, as indicated below, my medical record information including behavioral health/psychiatric treatment records:

☐**Obtain** ☐**Release**

Name/Facility: _____ **Attn**: _____

Address: _____ **Phone**: _____

City: _____ **State**: _____ **Zip**: _____ **Fax**: _____

Form of Release:

☐ Mail Copies To: ☐ Discuss Medical Record Information:

☐ Other (please describe): _____

Unless otherwise prohibited by law, a fee for medical records may be charged. ($15 clerical fee plus $0.50 per page for first 100 pages, and $0.25 per page thereafter plus postage.)

Dates of Service: _____ (If left blank, records for the last 12 months of treatment will be released)

Please indicate the SPECIFIC information to be disclosed:

☐ Presence/Progress in Treatment ☐ Progress/Collateral Notes

☐ Clinical Assessment Information ☐ Discharge/Transfer Summary

☐ Individualized Action/Treatment Plans ☐ Psychiatric Summaries/Medications

☐ Medical Health Summaries ☐ Psychological/Neuropsychological Testing Results

☐ School Information ☐ Other (please describe) _____

Protected Information: I understand that the records below cannot be disclosed without my specific written consent as indicated by checking the boxes below.

☐ Substance Use/Treatment ☐ Domestic Violence/Counseling ☐ Genetic Testing

☐ HIV/AIDS Results/Treatment ☐ Sexual Assault/ Counseling ☐ Sexually Transmitted Infections

☐ Other (please describe) _____

Sharing of Information within Beth Israel Lahey Health System: By signing this form, I authorize BILH BS to share the protected information described in this form internally within Beth Israel Lahey Health and its affiliates, as is necessary for my treatment. I understand that BILH BS will only share such information to the minimum extent necessary and that such information remains protected externally of Beth Israel Lahey Health except as authorized by this form.

The purpose of this release of information is:

☐Treatment ☐Insurance ☐Legal ☐Personal ☐ Care Coordination

☐Other (please describe) _____

I understand that my records are protected under the Federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I have the right to inspect and copy the information to be disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by law. I understand that I have a right to revoke this Authorization. I must do so in writing and present my written revocation to the BILH BS Site or Program Director or designee. I understand that the revocation will not apply to information that has already been released in response to this Authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this Authorization will expire on the following date, event or condition listed below. I understand that I may refuse to sign this Authorization for any reason and that my refusal will not affect the commencement, continuation, or quality of my treatment at BILH BS, except, however, for medical safety or if my treatment at BILH BS is for the sole purpose of creating health information for disclosure to the recipient in this authorization, in which case BILH BS may refuse to treat me if I do not sign this authorization.

Authorization will expire: _____

If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from termination of treatment. If termination of treatment has already exceeded 90 days, this authorization will expire 90 days from the date indicated below.

_____ _____

Signature of Client/Parent/Legal Representative* Date

_____ _____

Print Name Relationship to Client

*If signing as a legal representative, provide appropriate paperwork to support representative status.