21 RAILROAD AVENUE | SWAMPSCOTT, MA 01907
5 CHERRY HILL DRIVE | DANVERS, MA 01923
P: (781) 600-5501
F: (781) 623-0220

AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

Client Name: ____ Date of Birth: ____________________

Address: ____ Phone: _________________________

I authorize Longwood Care to speak with/share my treatment information including progress notes, assessments, treatment plan, referral information and/or discharge summary with:

Individual/Provider/Agency: ____

Address: ____ Phone: _________________________

Special authorization for release of statutorily protected information from the medical record:

□ To the extent that my record contains information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by federally-assisted alcohol or drug abuse program, I specifically authorize release of such information.

□ To the extent that my record contains information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative, I specifically authorize release of such information.

□ To the extent that my record contains information regarding a genetic test, I specifically authorize release of such information.

□ To the extent that my record contains information regarding, abortion, rape/sexual assault, sexually transmitted diseases, domestic violence, child/elder/disabled abuse I specifically authorize release of such information.

□ To the extent that my record contains information regarding behavioral/mental health, I specifically authorize release of such information.

This authorization will remain in effect for 90 days after signed/dated below or as specified: _________________

I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Longwood Care. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the Longwood Care office at 21 Railroad Ave, Swampscott, MA 01907.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client/Parent/Legal Guardian: ____

Signature: ____Date: ____________________