Community Neuroscience Services
Authorization to Release/Disclose Medical Records

(This authorization complies with HIPAA)

Printed Name of Patient (first, middle, last name)	Birthdate (mm/dd/yyyy)
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Printed Name of Guardian or Legal Representative (first, middle, last name)	
Address (Street Address, City, State, Zip Code)	
Phone Number	E-mail

Release information **from** the health care provider/ organization specified below

Person/Organization to Release Information		
Street Address		
City	State	Zip Code
Phone Number	Fax Number	

Release information **to** the above named patient **or** recipient specified below

Person/Organization to Receive Information **Community Neuroscience Services**		
Street Address **33 Lyman street Suite #400**		
City **Westborough**	State **MA**	Zip Code **01581**
Phone Number **508.898.0055**	Fax Number **508.898.0035**	

Patient Name: _____ **D.O.B:** _____

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

The following health information that relates to service beginning from _____ to _____, may be released:

- □ Consult Notes
- □ Discharge Summaries
- □ Labs, Diagnostic Testing, Imaging
- □ Mental Health Treatment, Therapy Notes
- □ Neuropsych Testing
- □ Other: _____

I further understand that my medical record may include one or more of the following:

Treatment of communicable diseases, including sexually transmitted diseases, venereal diseases, tuberculosis, or hepatitis, HIV-Related Treatment, Alcohol or Substance Abuse Treatment

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to, services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions for the purpose of:

- □ Change of Doctor
- □ Individual Request
- □ Workers Compensation
- □ Insurance Purposes
- □ Continued Treatment
- □ Legal Investigation
- □ Other: _____

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law. This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient or Personal Representative:	Date Signed:	Description of Personal Representative's Authority: