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Authorization for Release of Protected Health Information

Client Name: ______________________ **D.O.B.** ____________

Address: ______________________

____

City: ____________ **State:** ______ **Zip:** ________ **Phone:** ____________

I, ______________________ **hereby request/authorize the release of confidential information**
From / To: North Star Guidance Center, Inc. <u>And</u> From/ To:

Name: ______________________ **Title:** ____________

Address: ______________________

____

City: ____________ **State:** ______ **Zip:** ________ **Phone:** ____________
Fax:

* Massachusetts public health law g. L. C.111, s.70f and federal regulations provide special confidentiality protections for certain health records pertaining to substance abuse, mental health, and HIV/AIDS. A second written consent of the individual specifically releasing this information must be obtained. Please check boxes and initial below.

I request that the following information be released: (check all that apply)

- ☐ Medical record
- ☐ Academic record
- ☐ Treatment history
- ☐ Diagnosis Statement
- ☐ Other ______________________
  ____
- ☐ Educational Test Results
- ☐ Mental Health Information & Testing* **(initial)**
- ☐ Medical Test Results* **(initial)**
- ☐ Substance abuse information * **(initial)**

The purpose of this disclosure is:

- ☐ Multi-systemic support planning
- ☐ Enhance counseling/ psychopharmacology
- ☐ Other ______________________

I understand that I may revoke this release at any time, otherwise, this release will automatically expire two years from today's date, or by __________. No information released under the terms of this authorization may be re-disclosed without the written permission of the client.

Please direct information released to: ______________________

Client signature: ______________________ **Date:** ____________

Witness signature: **Date:**

Revised 2022