AUTHORIZATION TO EXCHANGE CLIENT INFORMATION

200 Ter Heun Drive
Falmouth, MA 02540
508-540-6550 ex. 5418
Fax: 508-564-9518
Gosnold.org

Patient Information (Please Print)

Patient Name : ____ Date of Birth: __________________

Patient Address: ____ Phone #: _____________________

City: ____________________________ State: ________ Zip: _________ Email: _______________________

I hereby authorize Gosnold to:

Please choose one or both: ◯ **Release my medical record information to** ◯**Obtain medical information from**

Name/Facility: ____ Relationship: _______________________

Address: ____ Phone #: __________________________

City: ________________________________ State: _______ Zip: ________ Fax #/Email: _______________________

Purpose of Request:

◯ To provide ongoing care/treatment
◯ Emergency contact
◯ Other (please explain): ____
◯ I am unable/refuse to provide a release of information for my emergency contact, Primary Care Provider or Behavioral Health Provider

Specific Records to be released/timeframe of release:

Release of Information valid for: ◯ **One time disclosure** ◯ **2 years unless revoked (in writing)**

Please choose one below:

◯ Please provide a presence in treatment letter. ◯Please provide billing information.
◯ Please provide a copy of 2 years of my records * ◯Please provide a copy of my entire record*
◯ Please communicate my presence in treatment with my emergency contact including but not limited to wellness checks, emergent hospitalizations, consecutive missed appointments
◯ Please provide a copy of my specific information as outlined below *

Program(s): ____________________Specific Information to Release:_______________ Date(s) of Treatment: ______ to _________

**** Copy fee may apply COPY FEE**: Pursuant to Chapter 135 of the Acts of 2003, "An Act Establishing Reasonable Fees for Copying Medical Records", Mass General Law Ch. 111, §70, we reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.*

Restricted Authorization to Release Protected Information:

IMPORTANT - It is extremely important that you select either you "DO" or "DO NOT" for each item contained in this section Authorization to Release Protected Information. Please do not skip any line item as it could impact our ability to fulfill your request and cause additional delays.

◯I DO ◯I DO NOT specifically authorize the release of information above regarding my mental health diagnosis or treatment.
◯I DO ◯I DO NOT specifically authorize the release of information regarding any alcohol, drug, and/or substance abuse, diagnosis or treatments.
◯I DO ◯I DO NOT specifically consent to the release of any test results for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical record. **

I understand that information disclosed in this request about substance abuse treatment is disclosed from records protected by Federal Confidentiality rules (42 CFR Part 2). Federal rules prohibit further disclosure of this information unless such disclosure is permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). Additionally, my signature below authorizes the release of my medical information regarding HIV antibody and antigen test as required by M.G.L. c.111 § 70F. A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I also understand that I may withdraw this permission at any time by submitting written notification of such revocation.

I have read and understand the above statements and do hereby voluntarily consent to the disclosure of the information and/or medical records (including alcohol/drug abuse records) to those persons/agencies named above. I hereby release Gosnold and its employees or representatives from any liability arising from the release of this information, provided said release of information is done substantially in accordance with applicable law.

**Note: Gosnold must obtain authorization for each requested release of HIV/AIDS information

Signature of Patient: ____ Date: ______________________

Signature of Guardian/Parent (when applicable): ____________________________________ Date: ______________________

Gosnold Staff Signature/Title: ____ Date: ______________________