McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Health Information Management
115 Mill Street, Mail Stop139, Belmont, MA 02478-9106
Telephone 617.855.2447

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name:____ **Date of Birth:**____________________

Specific information to be released:

☐ Verbal Information/Telephone Update
☐ Continuing Care Plan (Inpatient Only)
☐ Discharge/Treatment Summary
☐ Other *(specify)*____________________________

Purpose:

☐ Treatment
☐ Financial
☐ Personal
☐ Other______________________________

FROM McLean Hospital
to another person or facility

I hereby authorize McLean Hospital to release the above information to the following person or facility:

To: ☐Referring/Aftercare Clinician ☐PCP ☐Other

*Name/Facility:*____________________________________

Address: ______________________________________

____

____

To: ☐Referring/Aftercare Clinician ☐PCP ☐Other

*Name/Facility:*____________________________________

Address: ______________________________________

____

____

TO McLean Hospital
from another person or facility

I hereby authorize the following person or facility to release the above information to McLean Hospital:

*Name/Facility:*____________________________________

Address: ______________________________________

____

____

Information should be sent to:

McLean Hospital
115 Mill Street
Belmont, MA 02478-9106

Attention:

____

Name of McLean staff member who should receive the information

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Medical Records. Authorization may be withdrawn except to the extent that action has already been taken in reliance on this authorization. If the authorization was obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy, even if authorization has been withdrawn.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by McLean Hospital.
- This release will expire 90 days from the date below or as otherwise specified:__________________.

Mental Health Information. I authorize disclosure of such information.

Alcohol and Drug Abuse Treatment. To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

HIV Information. To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. Ch.111 §70f, I authorize disclosure of such information.

Patient or Patient Representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do *not* sign a blank authorization form.

____

Signature of Patient (if 18 or older);
or Parent (if patient is under 18);
or Legal Guardian; or Health Care Agent *(circle one)*

____

Signature of Witness

__________________________________ __________

Printed Name of Patient or Authorized Person Date

__________________________________ __________

Printed Name of Witness Date

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*Name/Facility:*__________________________________

Address: _____________________________________

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