ADCARE HOSPITAL
We Care
OF WORCESTER, INC.

508-799-9000 * 107 Lincoln St., Worcester, MA 01605

WRITTEN AUTHORIZATION FOR RELEASE OF INFORMATION

NAME OF CLIENT: _____ PHONE NO.: _____

DATE OF BIRTH: _____ EMAIL: _____

I DO HEREBY AUTHORIZE: **AdCare**

(NAME OF PROGRAM DISCLOSING INFORMATION)

TO DISCLOSE TO: _____ FAX NO.: _____

(NAME OF PROGRAM/ORGANIZATION/PERSON RECEIVING INFORMATION)

_____

STREET ADDRESS

_____

CITY STATE ZIP CODE

The following information: **Please specify dates of treatment:** _____

____ Discharge Summary/After Care Plan
____ History & Physical Examination
____ Psychosocial Assessment
____ Psychological/Psychiatric Evaluation
____ Progress in Treatment
____ Psychotherapy Notes
____ Consultation
____ Verification of Treatment (Date Letter)
____ Back to Work Letter
____ Other (Specify): _____

For the purpose of:

____ Coordination Services
____ Other (Specify)

Please INITIAL either the "YES" or "NO" response regarding release of information pertaining to HIV/AIDS.

____ YES. Information may be released.

____ NO. Please restrict release of information regarding above.

I UNDERSTAND THAT EXCEPT IN LIMITED CIRCUMSTANCES ADCARE HOSPITAL OF WORCESTER, INC. WILL NOT CONDITION MY TREATMENT ON WHETHER I GIVE AUTHORIZATION FOR THE REQUESTED DISCLOSURE.

I AM FULLY AWARE THAT THE FOLLOWING INFORMATION WHICH I AM AUTHORIZING ADCARE HOSPITAL TO RECEIVE OR SEND MAY BE DRUG OR ALCOHOL RELATED INFORMATION PROTECTED UNDER 42 C.F.R. PART 2 AND/OR INFORMATION REGARDING SEXUALLY TRANSMITTED DISEASES. FEDERAL LAW PROHIBITS THE PERSON OR ORGANIZATION TO WHOM DISCLOSURE IS MADE FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42C. F.R. PART 2.

I AM AWARE THAT I MAY WITHDRAW MY CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAD BEEN TAKEN IN RELIANCE ON THIS STATEMENT OF INFORMED CONSENT. I ALSO UNDERSTAND THAT EVEN IF I DO NOT WITHDRAW CONSENT, THIS STATEMENT OF CONSENT SHALL AUTOMATICALLY EXPIRE ON OR TWELVE (12) MONTHS POST DISCHARGE.

_____

Signature of Client, Parent, Guardian, or Legal Representative
(If other than client, please indicate capacity)

_____

(Signature of Witness)

_____

(Date)

Phone: 508-453-3019
Fax: 508-791-7483