McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

Release of Information
121 Inner Belt Road, Room 240
Somerville, MA 02143-4453
Phone: 617-726-2361
FAX: 617-726-3661

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name: ______________________ **Date of Birth:** ______________

Specific information to be released:
☐ Verbal Information/Telephone Update
☐ Discharge/Treatment Summary
☑ Other *(specify)* PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

Purpose:
☐ Treatment
☐ Financial
☐ *Personal
☑ *Other LEGAL - DISCOVERY BEFORE TRIAL

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

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

To: ☐ Referring/Aftercare Clinician ☐ PCP ☑ Other

Name/Facility: RECORDS DEPOSITION SERVICE, INC

Address: PO BOX 5054

SOUTHFIELD, MI 48086-5054

P:248-357-3330 F:248-357-3337 INFO@RECDEP.COM

Specific information to be released:
☐ Verbal Information/Telephone Update
☐ Discharge/Treatment Summary
☐ Other *(specify)* ______________

Purpose:
☐ Treatment
☐ Financial
☐ *Personal
☐ *Other ______________

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

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To: ☐ Referring/Aftercare Clinician ☐ PCP ☐ Other

Name/Facility: ______________

Address: ______________

**Copying fees may apply*

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*) ______________

Mental Health Information. I authorize disclosure of such information, including details of mental health diagnosis and/or treatment provided by a Psychiatrist, Psychologist, Licensed Mental Health Clinician, Advanced Practice Nurse, or Licensed Social Worker.

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management. Authorization may be withdrawn except to the extent that action has already been taken in reliance on this authorization.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other laws provide the insurer with the right to contest a claim under the policy, even if authorization has been withdrawn.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 180 days from the date below or as otherwise specified: __________.

YES *Please check yes for the following questions, to indicate if we may release information below (if it is in your medical record.)*

☐ **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.

☐ **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.

☐ Details of Domestic Violence Victims' Counseling

☐ Details of Sexual Assault Counseling

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)*

Printed Name of Patient or Authorized Person

Date