SOUTH MIDDLESEX OPPORTUNITY COUNCIL

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I _____ ____/____/____ _____/_____/_____
(name) (date of birth) (SS#)

am currently applying for/receiving services from the South Middlesex Opportunity Council. It is my understanding that my name, date of birth and social security number will be shared with the Worcester Police Department for the sole purpose of checking any outstanding warrants I may have.

I understand that I need not consent to have this information shared with the Worcester Police Department. Refusal will result in my being denied services.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

SMOC Greater Worcester Housing Connection

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I _____ ____/____/____ _____/_____/_____
(name) (date of birth) (SS#)

am currently applying for/receiving services from _____. It is my understanding that confidential information may need to be released/obtained to aid in case management, evaluation or treatment. This form constitutes authorization for releasing or obtaining information by the above listed agency and releases them from any liability arising from the release of information, provided that the information is released in accordance with applicable law.

I hereby authorize you to release complete information regarding my evaluation and/or treatment including copies of the following specific items:

_____

_____

To:/From:_____

_____

I understand that, by law, I need not consent to release this information; however, I choose to do so voluntarily. I understand that all information released should be held strictly confidential and that with written notification I may revoke this consent at any time except to the extent that action based on it has already begun. The authorization to release information expires six (6) months from the date signed below. A copy of the form shall be valid as an original.

_____ _____
Signature **Date**

_____ _____
Witness **Date**

SMOC Greater Worcester Housing Connection

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

When you complete this form, you are authorizing the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and federal laws concerning the privacy of such information. If you do not provide all the information requested, this Authorization may not be valid.

I authorize the following person(s) and/or organization(s) to disclose my protected health information (as specified below):
Name of Client_____ Maiden, Alias or Other Name _____
Date of Birth___/____/____ Social Security _____-____-_____
Number Street Address _____City_____ State_____ Zip _____

☐ **Disclosed From:** ☐ **Disclosed To:** _____

☐ **Disclosed From:** ☐ **Disclosed To:** ☐ **SMOC Greater Worcester Housing Connection (GWHC 1398 Main Street, Worcester, MA 01603, 508-757-0103**

Purpose of Requested Use or Disclosure

☐ Coordination of care or case
☐ At the request of the Client
☐ Response to court order or subpoena
☐ Treatment and follow up
☐ Response to HHS or other government management agency
☐ emergency release of information involving another mental health agency. SMOC may release necessary clinical information to insure appropriate clinical services at another mental health agency
☐ Other_____

Information to Which the Authorization Applies

Scope of Disclosure: PHI (Protected Health Information) that may be disclosed through this Authorization is as follows:
☐ All PHI contained in my Medical Records that have been generated by the Provider.
☐ All PHI (Protected Health Information) in my Medical Records that has been generated by the Provider excluding the following:_____
☐ Specific PHI (Protected Health Information) for the time period From:_____ To:_____ that includes
☐ All clinical information ☐ Admission Summary ☐ Psychiatric Assessment
☐ Treatment Plan ☐ Mental Status ☐ Psychosocial Assessment
☐ Discharge Summary ☐ Medical Examination
☐ Other (explain) Referral information, appointment time, attendance or lack of attendance at intake and follow up appointments.

To the extent that my PHI (Protected Health Information) includes alcohol or drug treatment that is protected by 42 CFR, Part 2:
☐ I specifically authorize its release ☐ I do not authorize its release
Signature: _____
To the extent that my PHI includes AIDS, ARC or HIV information that is protected by MGL Ch. 111 70f:
☐ I specifically authorize its release ☐ I do not authorize its release
Signature: _____
To the extent that my PHI includes STD'S, TB, or HEP C information that is protected
☐ I specifically authorize its release ☐ I do not authorize its release
Signature: _____

This authorization expires (date or event): _____

Notice of Rights and Other Information

I may refuse to sign this Authorization. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this Authorization. I may take back ("revoke") this Authorization at any time. To revoke this Authorization, I must send a letter, which has been signed by me or on my behalf to**: Greater Worcester Housing Connection, 1398 Main Street, Worcester, MA 01603.** My revocation will be effective upon receipt, but will not affect disclosures already made in reliance on prior consent.

Except as described above with respect to drug and alcohol abuse records, information disclosed as a result of this Authorization could be redisclosed by the recipient and might no longer be protected by federal confidentiality laws. I may inspect or obtain a copy of the health information to be used or disclosed as permitted under federal or state law

Signature: _____ Date: _____Time: _____ am/pm
Client / Individual/Member/Authorized Representative
Witness : _____ Date: _____Time: _____ am/pm

If signed by someone other than the individual or Member, state your legal relationship to the individual or Member:

- legal relationship _____