Elevate Counseling Services, Inc.

117 EASTMAN STREET #102, SOUTH EASTON, MA 02375
116 MECHANIC ST., #7, BELLINGHAM, MA 02019
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PH: 508.202-1811
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name_____________________________DOB _____________

1) I authorize __________________at Elevate Counseling Services, Inc.
to release/exchanged health information with:
____
____

2) I authorize
____
____

to release/exchange information with ___________________at Elevate Counseling Services.

Please specify the health information authorized to release:
Medical _____ Mental Health _____
Types of health information: _______________________________
Dates) of Treatment: _____________________________________

The following information will not be released unless you specifically authorize it by checking the relevant spaces below.
1 I specifically authorize the release of information pertaining to drug and alcohol abuse, diagnosis and treatment _____
2 I specifically authorize the release of HIV/AIDS test results_____

Name________________________________DOB _____________

The purpose of this release is for:
request of patient or patient representative________
Other____

NOTICE
Your clinician at Elevate Counseling Services and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.
YOUR RIGHTS
This authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except in the following cases. (1) To conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) to create health information to provide to a third party.
This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative and delivered to Leigh-Ann Larson, Director, Elevate Counseling Services, Inc. You are entitled to receive a copy of this Authorization.
EXPIRATION OF AUTHORIZATION
Unless otherwise revoked, this authorization expires on ______if no date is indicated, the Authorization will expire 12 months after the date of signing this form.

Print Name:____________________
Signature: __________________________ Date: ___________