1069 Central Street, Leominster MA 01453 T: 978.728.4957 F: 978.798.1366

AUTHORIZATION/REQUEST FOR RELEASE of MEDICAL HEALTH RECORD

(Also known as Protected Health Information)

Date: / /

Patient Name _____ Date of Birth _____

Address _____

Provider Information

*Primary Care Physician or other Medical Professional

Name _____

Address _____

Phone Number_____

Fax Number _____

Please fax TAK Center for Mental Health the last office note/physical exam, any brain MRI/CT Scans, neurological testing, and most recent labs for the patient listed above to 978.798.1366

Behavioral Health Provider Information
Name Dr. Ramteen Rezai
Address 1069 Central Street, Leominster, MA 01453
Phone Number 978.728.4957
Fax Number 978.798.1366

I, (or on behalf of) _____ give permission to the providers listed above to exchange information about my medical and behavioral health.

In addition:

I authorize the exchange of information about any substance or alcohol abuse in my medical records.

[ ] Yes [ ] No

I authorize the exchange of information about any HIV blood tests results or HIV- or AIDS- related care in my medical records.

[ ] Yes [ ] No

1. I understand that, unless withdrawn, this authorization will expire 1 year from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the TAK Center for Mental Health at the address indicated above, in writing, and this authorization will cease to be effective on the date notified unless the information has already been released.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I hereby release all parties stated herewith from any liability resulting from the release of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative Relationship and Date

_____ _____
Printed Name of Authorized Representative Date

Refusal to Release Information

[ ] I do not consent to release the information as described above. However, I understand that if I do not allow my providers to exchange information about me, their ability to fully coordinate my care may be limited. I understand that in an emergency situation my providers may exchange information about me to the extent necessary.

Signature of patient/guardian _____ Date _____