ADVANCED PSYCH SERVICES
425 Lake Ave N Ste 101
Worcester, MA 01605
Tel: (508) 753-3220 Fax: (508) 753-3224

Medical Records & Information Authorization Form

PLEASE PRINT CLEARLY

First Name:_____ Last Name:_____

D.O.B: ____/____/_____ Tel: ( )_____ - _____

Purpose of Request

☐ For APS to DISCLOSE and OBTAIN information from the below provider

☐ For APS to ONLY DISCLOSE information to the below provider

☐ For APS to ONLY OBTAIN information from the below provider

Name of Provider/Facility *(Phone number only is sufficient)*

Name: _____

Phone: ( ) _____ - _____

Fax: ( ) _____ - _____

Mail to address:_____

Information to be Obtained or Disclosed | Communication Method ☐ Any ☐ Verbal Only

☐ *Medical Records (excludes psychotherapy notes and labs unless checked below)
☐ **Psychotherapy Notes (Must check to be included)
☐ **Drug Screening/Lab Results (Must check to be included)
☐ HIV/AIDS _____ (Must initial)
☐ Other (must specify) _____

☐ Initial Evaluation
☐ Medication List
☐ Problem List/Diagnosis
☐ Progress Notes
☐ Appointment Compliance
☐ Correspondence

Dates of service to be disclosed:

☐ All Dates **OR** ☐ FROM / / TO / /

Releases remain valid for one year, unless otherwise noted:

Valid Until: / /

I, the undersigned patient or legal representative, hereby voluntary authorize the use and disclosure of health information as indicated above. This authorization may be valid for up to **one year** from the date below. I understand that I may revoke this authorization at any time by notifying medical records in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that I may request to inspect or copy the information to be used or disclosed. **I understand there may be a charge for copies**. The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian.

_____ __/__/____

Patient Signature or Legal Representative Date

Legal Representative Print Name:_____

HIV RELATED INFORMATION: In the event that information release constitutes confidential HIV related information protected under Massachusetts Law: This Information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. *PSYCHIATRIC INFORMATION:* If the event that information released constitutes confidential psychiatric information protected under Massachusetts Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient