Authorization for Release and/or Discussion of Protected Health Information

If you want Angela Madge, LEP to release and receive specific health and medical information with another person or organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, ______________________________, give my permission for Angela Madge, LEP
(print your name)
to receive and share the information that I list in Section II with the person(s) or organization listed below:

I. ____
Name or Organization   Address   Phone Number

II. ____
Name or Organization   Address   Phone Number

SECTION II

A. Health and Personal Information

Please describe the information you want Angela Madge, LEP to share or receive about you. Please include any dates and details you want to share.

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B. Permission about Specific Health Information.

Only if you choose to share any of the following information, please write your initials on the line:

______Mental Health Information
______HIV/AIDS Information
______Genetic Testing Information
______Drug/Alcohol Diagnosis, Treatment, or Referral Information

SECTION III – Reason for Sharing/Receiving this Information
Please describe the reason(s) for sharing/receiving this information. If you do not want to list reasons, you may simply write: “at my request,” if you are initiating the request.

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SECTION IV– How Long This Permission Lasts
This permission to share/release my information is good until ______________.
Indicate date or event
If I do not list a date or event, this permission will last for one year from the date it is signed.

• I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to Angela Madge, LEP and send it or bring it to 525 Massachusetts Ave, Suite 101G, Acton MA 01720. If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.
• I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section I.
• I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature
Please sign and date this form, and print your name.

________________________________ ____________________
Your Signature Date

____
Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: __________________________

Signature of the person filling out this form: _____________________________________

Describe how this person has legal authority for this individual:____________________