COUNSELING SERVICES OF GREATER BOSTON, LLC
WWW.CSGBOSTON.COM
7 LINCOLN STREET, SUITE 216 • WAKEFIELD, MA 01880
Office: (781) 328-1904 Fax: (781) 328-4733

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ____ DOB: ________________

I hereby authorize Counseling Services of Greater Boston, LLC to obtain and release confidential health information as specified below (please initial):

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
_____ Educational Information
_____ Nursing/Medical Information
_____ Substance Abuse Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information
_____ Psychotherapy Notes
_____ Other (please specify):_______________________
_____ Other (please specify):_______________________

My protected health information will be released to/obtained from:
Name of Contact & Role: ____
Organization (i.e. school/office): ____
Address: _______________________________ City: _____________ State: ________ Zip Code: ____________
Phone: ______________________ Fax: __________________ Email: ____________________________________

Purpose: This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify: ___________________________________
____

I may revoke this authorization at any time, in writing, except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) one year after I have terminated treatment, unless otherwise indicated here: ____

Form of Disclosure: Unless specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records.

___________________________________ ________________________________ _______________
Signature of Client/Legal Representative **Full name and relationship to Client** **Date**