Sweeney Dawley Recovery Center

409 Pond Street, Suite 9
Braintree, MA 02184
781-268-2638

Authorization for the Release and/or Discussion of Protected Health Information

Printed name of Patient: _____

SS#: _____ Date of Birth: _____

I, _____, authorize the Sweeney Dawley Recovery Center to use and/or disclose certain protected health information about me to (provide name and address of entity to receive info)

_____ .

This authorization permits the Sweeney Dawley Recovery Center to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as dates of service, type of services, etc.)

Medical Mental Health information.

The release of this information is at my request and is requested for the following purpose

Coordination of Care.

I do not have to sign this authorization in order to receive treatment from the Sweeney Dawley Recovery Center. In fact, I have the right to refuse to sign this authorization.

I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or agency(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by them may not be protected by the HIPAA Privacy Rule or those laws.

I have the right to revoke this authorization at any time, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to Ethel Dawley, the Sweeney Dawley Recovery Center privacy officer, 409 Pond Street, Suite 9, Braintree, MA 02184.

I authorize the use of a copy of this form for the disclosure of the information described above.

_____ _____
Signature Date

_____ _____
Witness Date