**Authorization to Use/Disclose Health Care Information**

Starr Psychiatric Center
529 Pearl Street
Brockton, MA 02301
**Phone: 508-580-2211 Fax: 508-427-1772**

Patient Name:__________________________________________ Date of Birth: ___________

Maiden Name (if applicable):_____________________________________________________

**I request and authorize:**

Name: ___________________________________________________________

Address:__________________________________________________________

City, State, Zip:____________________________________________________

Phone:___________________________ Fax#:___________________________

**To release healthcare/school information described below to:**

Name: ___________________________________________________________

Address:__________________________________________________________

City, State, Zip:____________________________________________________

Phone:___________________________ Fax#:___________________________

**Please check to specifically authorize the use and/or disclosure of:**

Emergency Room/Urgent Care Records:_________ Admission Note: _________

Hospital Records (nursing and progress notes): _________ Discharge Summary: _________

Initial Psychiatric Evaluation: _________Clinical Summary: _________

Medication History: _________Outpatient Progress Notes: _________

Consultation Report (specify):____________________________________________________

Laboratory Report (specify):______________________________________________________

X-Ray Report (specify):__________________________________________________________

Billing Statements: _________Verbal Discussion of Case: _________

Other (specify):_______________________________________________________________

**The requested records or information is about healthcare provided during the following approximate time frame:_______________________________________________________**

Purpose(s) of this use/disclosure: To obtain the mental health and/or other health information relative to the treatment of the individual listed on this consent.

**Authorization expires:________________________________ (one year from date of signing).**

I understand that, unless action has already been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to David Starr, M.D. or his professional associates. I understand that the Starr Psychiatric Center may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

Note: State law prohibits re-disclosure without written authorization.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

**Signature (patient or authorized representative):_____________________________________**

**Date: _____________**

**Relationship/authority (if signed by authorized representative): _______________________**

**I have received a copy of this signed authorization (please initial)_________ yes_________no**