PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize **Beacon Behavioral Health Associates, PLLC (BBHA) and/or Cheryl Greene 243 Main Street Buzzards Bay 02532 (phone) 508-743-5542, (FAX) 774-247-4289)** to:

Name:_____

Address:_____

Phone:_____Fax:_____

the medical and psychiatric records pertaining to my treatment from the period:

_____ through _____.
Including diagnostic and treatment information or other relevant notations. I hereby hold the practice harmless for the release of such information. This released information may be used solely for the purpose of continuity of medical care. This authorization is valid for the period of _____ through _____.

Under federal guidelines, information about diagnoses and treatment of alcohol and drug abuse, or HIV status may not be released without specific authorization.

I, _____, specifically authorize release of information concerning drug and/or alcohol abuse.

I, _____, specifically authorize release of information concerning HIV testing or diagnosis.

It is my understanding that this information will be used solely for the purpose described above. I am not giving permission for re-disclosure of the information. I understand that I may revoke my permission at any time except after the information has already been released.

I understand that the information obtained and/or released may be verbal or written and may be transmitted electronically.

Signature of Patient Date

Signature of Parent/Guardian (if applicable) Witness Date