Wayside Youth & Family Support Network
1 Frederick Abbott Way
Framingham, MA 01701

Authorization to OBTAIN OR DISCLOSE PROTECTED HEALTH INFORMATION

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the following program (circle one) of Wayside Youth & Family Support Network:

Wayside Campus Residential Wayside Day Center Wayside Academy **1 Frederick Abbott Way** **Framingham, MA 01701**	MetroWest Counseling Trauma Intervention FamilyWorks **10 Asylum St.** **Milford, MA 01757**	MetroWest Counseling Community Service Agency FamilyWorks **88 Lincoln St.** **Framingham, MA 01702**	Beaverbrook Counseling HomeBase **118 Central St.** **Waltham, MA 02453**	HomeBase **6 Pleasant St.** **Suite 220** **Malden MA 02148**	Twelve Prescott **12 Prescott St.** **Arlington, MA 02474**

To (check one):
DISCLOSE TO: _____, RECEIVE FROM: _____, DISCLOSE TO AND RECEIVE FROM: _____

Person/Organization/Self/Legal Representative:
_____

Address/Phone: _____

Role: _____

On Behalf of (client's name):_____**Clients DOB:** _____

Date of Authorization: _____

my individually identifiable protected health information. Health information includes information collected from me or created by the Provider, or information received by the Provider from another health care provider, a health plan, my employer or a health care clearinghouse.

SECTION B: SCOPE OF USE OR DISCLOSURE

Health information that may be used or disclosed through this Authorization is as follows:

- ❑ All health information about me, including my clinical records, or information received by the Provider. This information may include, if applicable: (check all that apply)
  - ❑ Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;
  - ❑ Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (i) this test is ordered, performed, or reported and (ii) the test results are positive or negative.
- ❑ Specific health information **including only:** (list of specific documents or information to be shared)

_____

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are): Check one:

- ❑ Treatment Coordination Other: _____
- ❑ Initiated by the Client and the Client does not elect to disclose its purpose. *Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment.*

SECTION D: EXPIRATION

This Authorization expires on: _____ (date) or in the event that _____
_____, whichever occurs first. **The event may be "treatment terminates".**

Note: If an expiration event is used, the event must relate to the Client or the purpose of the use or disclosure.

Name of Person/Organization/Self/Legal Representative for whom this Authorization is created:

_____

Address: _____

SECTION E: OTHER IMPORTANT INFORMATION

1. I understand that the Provider cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from Wayside Youth and Family Support Network, except when I am (i) receiving research-related treatment or (ii) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment from Wayside

3. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received Wayside Youth and Family Support Network. I further understand that that I must provide any notice of revocation in writing to the Privacy Office at Wayside Youth and Family Support Network. The address of the Privacy Office is: 1 Frederick Abbott Way, Framingham, MA 01701.

I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Client's signature: _____ Date of signature: _____

Print Client's full name: _____

Client's Home Address: _____

Client's Home Telephone: _____ Date of Birth: _____

When client is a minor or not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

Signature of legal representative: _____ Date of signature: _____

Print name: _____

Relationship of representative to client: _____

The Client should be provided with a copy of the signed Authorization.