SPRINGFIELD SPECIALTY COURT: MENTAL HEALTH SESSION

The Adult Court Clinic
Hampden Hall of Justice
50 State St. Springfield, MA 01103
413 748-7701 (phone)
413 737-7157 (fax)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

When you complete this form, you are authorizing the disclosure and/or use of your protected health information, as described below, consistent with state and federal laws concerning the privacy of such information. This authorization will be kept on file to allow future contact with Agencies/Persons listed below.

Client Name: _____
Social Security #: _____-____-_____
Date of Birth: ___/___/___

I,_____ , hereby authorize the **Springfield Specialty Court: Mental Health Session Case Manager and the Behavioral Health Network, Inc—Forensic Mental Health Services** to communicate with and disclose all health and clinical information with the following:

1. _____
   name address phone fax
2. _____
   name address phone fax
3. _____
   name address phone fax
4. _____
   name address phone fax
5. _____
   name address phone fax
6. _____
   name address phone fax

PURPOSE OF REQUESTED USE OR DISCLOSURE

The purpose of this Authorization is to determine eligibility for the Springfield Specialty Court: Mental Health Session, to provide continuity of care and case management, to develop a treatment plan and follow-up with services, and to assess my attendance and progress in treatment.

This authorization expires automatically upon the final disposition of my case or two years from the date below, whichever is first.

INFORMATION TO WHICH THIS AUTHORIZATION APPLIES

____ All health information pertaining to any medical history, mental or physical condition, and treatment received

____ All health information pertaining to any medical history, mental or physical condition, and treatment received, except:

_____

Only the following records or types of health information (including any dates):

_____

____ I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to re-disclose this information.

Signature:_____

____ I specifically authorize the release of information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV)

Signature:_____

I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my providing or refusing to provide this Authorization. I also understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically upon the disposition of my Mental Health Court case or two years from the date below, whichever is first?

I consent that information about my **Springfield Specialty Court: Mental Health Session** application and participation may be used in outcome studies to assess the impact of this program on participants. I further understand that my confidentiality will be maintained and any results will be disseminated in a manner to protect individual participant's identities.

Except as described above with respect to drug and alcohol abuse records, information disclosed as a result of this Authorization could be re-disclosed by the recipient and might no longer be protected by federal confidentiality laws.

I may inspect or obtain a copy of the health information to be used or disclosed under federal or state law. In addition, I have been provided with a copy of the form.

_____ _____

Signature of client or legal representative Date

_____

Print name of client or legal representative