JAMES LEVINE & ASSOCIATES
Your Partner in Behavioral Health Solutions

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 (PHI), to the person(s) you designate as described below, consistent with state and federal laws concerning the privacy of such information.

Client Name: _____
Date of Birth: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize James Levine & Associates, P.C. to:
Release Information to: _____
Name: _____ Address: _____ Phone: _____
Obtain information from: _____
Name: _____ Address: _____ Phone: _____

PURPOSE OF REQUESTED USE OR DISCLOSURE

I am authorizing James Levine & Associates to release this information for the following reasons: ("at the request of the individual" is all that is required if you are the client and you do not desire to state a specific purpose.)

☐ Coordination of Care ☐ Educational ☐ At the request of the individual
Other: (specify) _____

INFORMATION THAT MAY BE USED OR DISCLOSED THROUGH THIS AUTHORIZATION

☐ Psychological/Diagnostic Evaluation
☐ Educational Assessment
☐ School Records
☐ Treatment Progress / Status
☐ Medical History
☐ Developmental History

I specifically authorize the release of PHI relating to drug and/or alcohol abuse. I understand that my records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Records and cannot be disclosed without my written consent unless otherwise provided for in the Federal regulations. The recipient of drug and/or alcohol abuse information as a result of this authorization will need 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: _____

NOTICE OF RIGHTS

I understand that I may revoke this authorization in writing at any time, except to the extent that James Levine & Associates, P.C. has taken action in reliance on this authorization. Otherwise, this document does not expire.

I understand that this authorization is voluntary and that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to receive treatment from James Levine & Associates.

If my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Regulations.

Client's Name (printed): _____ Date: _____
Client's Signature: _____ Date: _____

When a client is not competent to give consent, the signature of a Parent, Guarantor, Health Care Proxy or Legal Representative is required.

Legal Representative's Name (printed): _____ Date: _____
Legal Representative's Signature: _____ Date: _____

James Levine & Associates
9 College Street Suite 6
South Hadley, Ma. 01075
Phone (413) 534-7400
Fax (413) 534-7483

JAMES LEVINE & ASSOCIATES
Your Partner in Behavioral Health Solutions