**MARGARET M. SHEA RN ADULT DAY HEALTH PROGRAM**

***Formerly Mattapan Adult Day Health Program***

229 RIVER STREET

MATTAPAN, MA 02126

Phone: 617-298-7970 FAX: 617-298-051

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)**

Please complete, sign and return this form to*:*  Mildred Lewis, mildred.lewis@bmc.org *or* submit via fax to 617-298-0517. Please contact us at 617-298-7970 with questions.

PARTICIPANT INFORMATION MR#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTICIPANT NAME: DOB:

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Last, First, MI Month/Day/Year

I hereby authorize,

Name of Facility or Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Including City, State, and Zip Code

Facility or Provider Telephone #: \_\_\_­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , to release my protected health information to:

Name of Designated Recipient: Marie Romelus, BSN/RN

MARGARET M. SHEA RN ADULT DAY HEALTH PROGRAM

 229 River Street

 Mattapan, MA 02126

 Phone: 617-298-7970 Fax: 617-298-0517

Protected Health Information to be released:

[x]  The most recent 6 months of pertinent information (chart notes, labs, x-rays and special tests)

[x]  Specific information*: Please include documentation of recent PPD or chest x-ray results.*

PURPOSE OF DISCLOSURE (Please check one)

[x]  Continuity of Care [x]  Care Planning

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PARTICIPANT AUTHORIZATION

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. (Initial specific protected health information).

[ ]  Drug/Alcohol abuse/treatment and diagnosis [ ]  Sexually transmitted disease

[ ]  HIV/AIDS diagnosis/treatment/testing [ ]  Mental Illness or psychiatric diagnosis treatment

MY RIGHTS:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment.) I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed has reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Participant, guardian, or Authorized representative