AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient name: _____Date of Birth: _____
   Address: _____

3. Information to be disclosed to:
   Address: C/O Health Care Partners
   1807 Bridge St. Unit #9
   Dracut, MA 01826

4. Disclose the complete records for treatment dates: _____to Present.

   I authorize this release with the understanding that it may include information in one or more of the following categories:

   a) Information relating to sexually transmitted diseases, excluding HTLV-III test results.
   b) Communication between a patient and a sexual assault or domestic violence counselor regarding sexual assault or domestic violence.
   c) Information related to drug and/or alcohol abuse.

   I HAVE PLACED A LINE THROUGH AND INITIALED ANY OF THE ABOVE MENTIONED INFORMATION THAT I DO NOT WISH TO BE RELEASED

5. The above information is disclosed for the following purposes: {please circle one of the following}
   Legal Insurance Medical care

6. I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires on {upon} _____{insert applicable date or event}. If not otherwise indicated, authorization will expire 90 days from the date signed.

I hereby acknowledge that I have read or have had read to me, and fully understand the above statements as they apply to me. I fully understand that the medical record may contain sensitive information as outlined above and do herein expressly and voluntarily consent to the disclosure of this protected health information for the purpose or need stated above. I need not sign this form to ensure healthcare treatment.

_____ _____

8. Signature of Patient or Legal Representative 9. Date

_____ _____

Printed name of patient or patient's representative 10 Relationship to patient or authority to act for patient

IMPORTANT: THIS AUTHORIZATION SHALL BE DEEMED INVALED UNLESS ALL NUMBERED ENTRIES ARE COMPLETED.