Brandon

Together We Can Achieve

In Cooperation with Advocates Community Counseling Inc.

RELEASE: AUTHORIZATION FORM FOR THE USE OR DISCLOSURE OF INFORMATION

Client's Name: Kula Michael **DOB:** 9/18/2000
Last Name First Name Middle Name

By signing this authorization, I authorize the use or disclosure of my Protected Health Information (PHI) designated below between:

Brandon School and Residential Treatment Center, Inc. • 27 Winter Street • Natick, MA 01760•
Advocates Community Counseling, Inc. • 1 Clark Hills •Suite 305 • Framingham, MA

And, the following organization:

Name of Organization: DCF Address: _____

Contact Person: _____ Phone Number: _____

Information includes information collected from me or created by the above Providers/Organizations, or information received by the above Providers from another provider, a health plan, my employer or a health care clearinghouse. Information may relate to my past, present or future physical or mental health or condition, academics, the provision of my healthcare, or payment for my healthcare services. I further understand that Brandon and its employees are prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part2). I further understand that under state law Brandon and its employees are prohibited from disclosing information about my HIV status without my specific written authorization. Brandon and its employees are also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatment of disease.

Information that may be used or disclosed through this authorization is as follows:

Check appropriate box(es)

☒ All information about me, including my health and dental records, academic records, clinical records, and other treatment records created or received by Brandon or any of its employees and the above listed Provider/Organizations, for the following purposes of **admissions, assessment, treatment, and transition planning.**

☒ Other specific information:

1. I understand that Brandon and its employees cannot guarantee that PHI disclosed to the above indicated person/organization will not be re-disclosed to a third party. The person/organization may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in an alcohol or drug abuse program, the person/organization is prohibited under federal law from making any further disclosure of such information unless further disclosure is permitted by written consent of the client or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42CFR, 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 (or payment, if applicable) from Brandon except when 1) My refusal may limit Brandon's ability to provide safe and effective care 2) I am receiving research-related treatment or 3) I am receiving care solely for the purposes of creating information for disclosure to a third party. If any of these exceptions apply, my refusal to sign an authorization may result in my not obtaining treatment (or payment, if applicable) from the provider.
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 Brandon or its employees in reliance on this authorization before written notice of revocation is received by Brandon or its employees. I further understand that I must provide any notice of revocation in writing to Brandon School and Residential Treatment Center, 27 Winter Street, Natick, MA 01760.

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. When client is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.
******This authorization expires one year from the date signed below:***

Michele Kula | Michele Kula | 24May17
Signature of Client or Parent/Guardian (PRINT NAME) Date

[signature] | Jared Plantier | 5-24-2017
Signature of Witness (PRINT NAME) Date

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Michele Kula | Michele Kula | 24May17
Signature of Client or Parent/Guardian (PRINT NAME) Date

Jared Plantier | Jared Plantier | 5-24-2017
Signature of Witness (PRINT NAME) Date