

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/	2002
	Last Name	First Name	Middle Name		
By signing this au between:	uthorization, I authorize	the use or disclosu	ire of my Protecte	d Health Information	n (PHI) designated below
	Brandon School and Re	sidential Treatmer	nt Center, Inc. • 27	Winter Street • Nati	ck, MA 01760•
	Advocates Comm	nunity Counseling, I	Inc. • 1 Clark Hills	•Suite 305 • Framingl	ham, MA
	DOE	And, the fo	ollowing organiza	tion:	
Name of Organ	nization: DCF			Address:	
Contact Person			Phone Numb	oer:	
provider, a health plai academics, the provis disclosing information regulations governing employees are prohib under state law from "informed written cor	n, my employer or a health car- ion of my healthcare, or payment about treatment for alcohol of Confidentiality of Alcohol and ited from disclosing information disclosing the results of a gene asent", except when the test report the purpose of generating so	e clearinghouse. Inforn ent for my healthcare se or drug abuse without m Drug Abuse Patient Rec on about my HIV status tic test (including the id esults disclosed will be u	nation may relate to mervices. I further under ny specific written auth cords (42 CFR, Part2). without my specific wr lentity of a person beir used only as confidentic	ly past, present or future p rstand that Brandon and it norization unless a disclosu I further understand that u ritten authorization. Brand ng tested) without first obt al research information for	ed by the above Providers from another hysical or mental health or condition, is employees are prohibited from ire is otherwise authorized by the federal under state law Brandon and its lon and its employees are also prohibited aining an authorization that constitutes ir use in epidemiological or clinical sease or for developing pharmaceutical
Information th	at may be used or di	sclosed through	this authoriza	tion is as follows:	
All informati	on about me, includi	ng my health ar	nd dental recor	ds, academic reco	ords, clinical records, and
other treatmen	nt records created or	received by Bra	andon or any o	f its employees ar	nd the above listed
Provider/Organ	nizations, for the foll	owing purposes	of admissions	. assessment, trea	atment, and transition
planning.	-	0, .		,,	
1. I understar third party. treatment i further disc governing (2. I understan applicable) treatment i refusal to s (3. I understan or its emplement or its emplement provided in the second of the se	nd that Brandon and its employ. The person/organization may information about a client in a closure of such information unl Confidentiality of Alcohol and End that I may refuse to sign this from Brandon except when 1) or 3) I am receiving care solely ign an authorization may result that I may revoke this author oyees in reliance on this author de any notice of revocation in verstand the terms of this author	y not be subject to feder n alcohol or drug abuse less further disclosure is Drug Abuse Patient Reco Authorization and that My refusal may limit Br for the purposes of crea t in my not obtaining tre rization in writing at any rization before written in writing to Brandon Scho	ral laws governing priv program, the person/o s permitted by written ords (42CFR, Part 2). I my refusal to sign will randon's ability to provating information for deatment (or payment, y time, except that the notice of revocation is ool and Residential Trea	acy of health information. organization is prohibited to consent of the client or as not affect my ability to ob- vide safe and effective care isclosure to a third party. if applicable) from the proving revocation will not have a received by Brandon or its atment Center, 27 Winter Sestions about the use or dis-	2) I am receiving research-related If any of these exceptions apply, my vider.  ny effect on any action taken by Brandor employees. I further understand that I Street, Natick, MA 01760.
vvnen client is not con	npetent to give consent, the sign expires one year from the date	gnature of a parent, au	pardian, health care ag	estions about the use or all sent (proxy) or other repre	sciosure of my health information. esentative is required.
Huste	le flele		Michele K	Sula	24May 17
Signature of Cli	ient Parent/Guard	Committee of the Commit		T NAME)	Date
f-//			tored Plan	rtier	5-24-2017
Signature of W	itness		(PRINT	NAME)	Date



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By signing this au between:	uthorization, I authorize	the use or disclosure of	my Protected Health	Information (PHI) designat	ted below
	Brandon School and Re	sidential Treatment Cer	nter, Inc. • 27 Winter !	Street • Natick, MA 01760•	1
	Advocates Comm	unity Counseling, Inc. •	1 Clark Hills •Suite 30	5 • Framingham, MA	
	. DOE	And, the follow	ing organization:		
	nization: DCF			ess:	
Contact Person	n:	P	none Number:		
provider, a health plan academics, the provision disclosing information regulations governing employees are prohib under state law from "informed written cor	n, my employer or a health cardion of my healthcare, or payment about treatment for alcohol or Confidentiality of Alcohol and ited from disclosing informatio disclosing the results of a general sent", except when the test report the purpose of generating so	e clearinghouse. Information int for my healthcare services or drug abuse without my spec Drug Abuse Patient Records ( in about my HIV status withou ic test (including the identity sults disclosed will be used or	may relate to my past, pres . I further understand that cific written authorization u 42 CFR, Part2). I further un t my specific written author of a person being tested) with as confidential research	primation received by the above Prisent or future physical or mental has Brandon and its employees are prinless a disclosure is otherwise autiderstand that under state law Brandon and its employed without first obtaining an authorization for use in epidemiolometic basis of disease or for develo	health or condition, rohibited from thorized by the federa andon and its ees are also prohibited ation that constitutes
	at may be used or di	sclosed through this	s authorization is a	is follows:	
Check appropr	1 /				
ather treatmen	on about me, includi	ng my health and d	ental records, acad	demic records, clinical r	records, and
Drovidor/Orga	nt records created or	received by Brando	on or any of its em	ployees and the above	listed
planning	nizations, for the foli	owing purposes of a	idmissions, assess	ment, treatment, and	transition
planning.	- !- f				
tring party, treatment i further disc governing ( 2. I understan applicable) treatment refusal to s 3. I understan or its emple	nd that Brandon and its employ. The person/organization may information about a client in a rclosure of such information unle Confidentiality of Alcohol and D id that I may refuse to sign this from Brandon except when 1) or 3) I am receiving care solely tign an authorization may resulted that I may revoke this author oyees in reliance on this author	not be subject to federal law alcohol or drug abuse progra- ess further disclosure is perm grug Abuse Patient Records (4 Authorization and that my re My refusal may limit Brandor for the purposes of creating in in my not obtaining treatme ization in writing at any time, ization before written notice	s governing privacy of healt am, the person/organization itted by written consent of 2CFR, Part 2). fusal to sign will not affect it's ability to provide safe an fformation for disclosure to nt (or payment, if applicable except that the revocation of revocation is received by	dicated person/organization will not information. However, if the did not prohibited under federal law for the client or as otherwise permitted my ability to obtain treatment (or and effective care 2) I am receiving not a third party. If any of these exceep from the provider.  In will not have any effect on any act of the second person or its employees. I further, 27 Winter Street, Natick, MA	isclosure consists of from making any ted under federal law payment, if research-related eptions apply, my ction taken by Brando
vvnen client is not con	stand the terms of this author npetent to give consent, the sig expires one year from the dat	inature of a parent, auardian	tunity to ask questions abo n, health care agent (ргоху	out the use or disclosure of my hed i) or other representative is require	alth information. ed.
Misse	li Dula		hele Bula	<u> 24ma</u>	417
Signature of Cli	ient of Parent/Guard	ian	(PRINT NAME	<b>(1)</b>	Date
f-/		1 Jor	ed Plantier		4-2017
Signature of W	itness		(PRINT NAME)	)	Date