NEWTON SQUARE COUNSELING COLLABORATIVE
338 HIGHLAND STREET
WORCESTER, MA, 10602
FAX 508-831-9967

PATIENT INFORMATION	Name _____ Date of Birth _____ Tel # _____ Street _____ City _____ State _____ Zip _____ Main Contact # _____
TYPE OF RELEASE AUTHORIZATION	___ **I authorize _____ to RELEASE** records to Name ---------- Street _____ City _____ State _____ Zip _____ ___ **I authorize _____ to OBTAIN** records to Name ---------- Street _____ City _____ State _____ Zip _____ ____ CHART REVIEW ONLY
PURPOSE OF REQUEST	____Continuing Care _____ Attorney ____Insurance Claim _____ Change Provider ____ Other _____
INFORMATION NEEDED Check all that apply	DATES From _____ TO _____ ____ Discharge Summary ____ Lab Results ____ Office Notes/History ____ Outpatient records ____ Inpatient records ____ Other
RELEASE OF SENSITIVE INFORMATION	Your separate signature is required by law to release sensitive information. Check all that apply ____ HIV Information ____ DO NOT release HIV information ____ Substance information ____ DO NOT release substance information **Patient/Guardian Signature _____**

I understand I have the right to revoke this authorization in writing at any time. Revoking does not apply to information already released and does not apply to my insurance company claim processing. Unless revoked, this authorization will expire one (1) year following the last submitted claim completed being processed.

Disclosing this health information is voluntary and I may refuse to sign. I need not sign to assure Treatment. I may inspect a copy or copy of the information to be disclosed as provided by CFR 164,524. I understand that disclosing this information carries the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I acknowledge I have received a copy of this form

Signature _____ Date _____