**AUTHORIZATION FORM for Exchanging Information**

### Justice Resource Institute

**PERSON SERVED (Name/DOB):**

By signing this Authorization, I authorize the use or disclosure of my Protected Health Information maintained **by**:

**NAME/ADDRESS:**

This information may be released under this Authorization **to Justice Resource Institute.**

**Written information should be mailed to this address** :

**ADDRESS** 555 Amory St, Suite 2, Boston, MA 02130

**ATTENTION:**

Health information includes information collected from me or created by the agency, or information received by the agency from another health care provider, a health plan, my employer or a health care clearinghouse. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

**[x]  Check here if you are allowing two way communication between the parties listed**

Health information that may be used or disclosed through this Authorization is as follows: (CHECK ONE):

[ ]  All health information about me, including my clinical records, created or received by person/organization above. (**including** HIV status, substance abuse/use, mental health records)

**OR**

[ ]  All health information about me as described in the preceding checkbox, **excluding** the following:

 **[ ] HIV status/records**

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

 **Note: Describe the health information to be excluded or included in a specific and meaningful fashion.**

# OR

[ ]  Specific health information including **only**:

# `` [ ] HIV status/records

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

**\*\*\**For HIV/AIDS records please note the following*\*\*\***

I also understand that HIV-related information about me is protected by State law and cannot be disclosed unless the disclosure is authorized by State law. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

**This Authorization expires**: \_\_\_\_\_\_\_\_\_\_\_ (Insert date) [ ]  90 Days – one time release [x]  One year

[ ] Upon discharge from JRI program - ongoing service provision by contracted/cooperating service provider.”

**The purpose(s) of this Authorization is (are):** [x]  Eligibility, planning, coordinating and service planning

[x]  Treatment planning, legal compliance [ ]  Determine legal restriction and court involvement [ ]  Aftercare planning

[x]  Coordinate/communicate regarding medical concerns and treatment [ ]  Eligibility for SSI, Medicare, MassHealth, and other subsidies [ ]  OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“If you have questions refer to your Privacy Notice. If you would like another copy of the Privacy Notice, ask your Program Director or Clinician and we will provide one for you. If you need additional information, contact the Program Director or JRI Privacy Officer.”

Acknowledgement:

“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. I understand that I may withdraw my authorization at any time. I have been provided with a copy of the signed Authorization.”

PERSON’ SIGNATURE

**Person’s signature:** **Date of signature**:

Print Person’s full name: Date of Birth:

GUARDIAN OR OTHER LEGAL REPRESENTATIVE SIGNATURE

When person is not competent or legally able to give consent, parent, guardian, health care agent signature

Signature of legal representative: \_\_\_\_\_\_ Date of signature:\_\_\_\_\_\_\_\_\_\_\_\_

Print name: Relationship to Person

[ ]  **Oral approval given.** Staff Signature: Date of signature:

FOR AGENCY USE ONLY – DOCUMENTATION BY PERSON SENDING THE INFORMATION/FORM

Date information/form sent/released: How it was sent = [ ] mail, [ ] email, [ ] fax

Sent by (name, title): Date Signed: