



# Serenity Coaching and Counseling, LLC

[www.SerenityMA.com](http://www.SerenityMA.com)    [Support@SerenityMA.com](mailto:Support@SerenityMA.com)

Phone: (508) 868-8070    42 Lake Ave. Worcester, MA 01604    Fax: (508) 519-6539

## Authorization For Release of Healthcare Information

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Specific Information to be released:**                      **Purpose:**                       **Consent Denied**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> My entire record, excluding progress notes | <input type="checkbox"/> Treatment    |
| <input type="checkbox"/> Verbal Information/Telephone Update        | <input type="checkbox"/> Coordination |
| <input type="checkbox"/> Discharge or Treatment Summary             | <input type="checkbox"/> Personal     |
| <input type="checkbox"/> Attendance Only                            | <input type="checkbox"/> Legal        |
| <input type="checkbox"/> Other: Letter stating receiving services   | <input type="checkbox"/> Other: _____ |

I hereby authorize Serenity Coaching and Counseling to obtain and release the above information with the individual/agency listed below:

Name/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Information (phone/fax/email): \_\_\_\_\_

**I understand that:**

- I may withdraw my authorization at any time by submitting a written request. Authorization may be withdrawn except to the extent that action has already been taken in reliance on this authorization.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits with not be affected.
- Information on this authorization, if redisclosed by the recipient, is no longer protected by Serenity Coaching and Counseling.
- This release with expire 90 day from the date of termination or as otherwise specified: \_\_\_\_\_

**Mental Health Information.** I authorize disclosure of such information.

**Alcohol and Drug Abuse treatment.** To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

**HIV Information.** To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. Ch. 111 70f, I authorize disclosure of such information.

\_\_\_\_\_  
Client/Parent/Guardian Signature

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed name of Client/Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Witness

\_\_\_\_\_  
Date