



William J. Gould Associates, Inc
GOULD FARM
PO Box 157
100 Gould Road
Monterey, MA 01245
Tel: 413-528-1804
Fax 413-645-1022

Authorization for Use or Disclosure of Health Information

Client's Name (please print) _____

Date of Birth _____ Social Security # _____

I hereby authorize _____

Address: _____

Covering the period(s) of health care from _____ to _____

Information to be disclosed:

- Psychiatric and Medical Evaluations
- Admission and Discharge Summaries
- Treatment Summaries
- Progress Notes

To be disclosed: Gould Farm Boston Area Programs

Check here if you are allowing two-way communication between the parties listed above.

This information will be used / disclosed for the coordination of care and treatment planning, with the following limitations _____

My medical record may contain information about HIV, alcoholism, and drug and/or alcohol abuse.

- I am willing to have this information disclosed
- I am not willing to have this information disclosed.

I understand that I have the right to refuse to sign this authorization.

I understand that I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information already released in response to this authorization.

I understand that I may inspect or copy any information used/disclosed under this authorization.

This authorization is valid for one year from the date it was signed OR for the duration of my treatment by Gould Farm and the Boston Area Programs, whichever occurs first.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Client or Legal Representative

Date: _____

Print name of Legal Representative (if applicable) and provide copy of legal documentation granting authority.

A signed copy of this form will be provided to the client.