GOULD FARM
Harvesting Hope ◆ Promoting Recovery

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Release of Information Form

Client name

DOB SS#

I hereby authorize

Address

Covering the period(s) of health care from to

Information to be disclosed:

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

To be disclosed to:

- ☐ 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 treament by Gould Farm and the Boston Area Programs, whichever comes first.

The facility, it's 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 legaldocumentation granting authority.

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