ANDOVER POLICE DEPARTMENT

32 NORTH MAIN STREET
ANDOVER, MASSACHUSETTS 01810
sobhan.namvar@andoverps.net
P: (617) 642-7274
F: (978) 475-7843

Sobhan Namvar, LICSW
COMMUNITY SUPPORT
COORDINATOR

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION

Client Name: _____ **Date of Birth:** _____

Specific information allowed to be released:

- ☐ Verbal Information/ Telephone Update
- ☐ Continuing Care Plan (Inpatient Only)
- ☐ Discharge/ Treatment Summary
- ☐ Other (Specify) _____

Purpose:

- ☐ Treatment
- ☐ Financial
- ☐ Personal
- ☐ Other _____

From Community Support Services Town of Andover

I hereby authorize Community Support Services, Town of Andover to release information to the following person/ Facility:
To:
Name/Facility: _____
Address: _____
Phone: _____

To Community Support Services Town of Andover

I hereby authorize the following person or facility to release information to Town of Andover's Community Support Services:
From:
Name/Facility: _____
Address: _____
Phone: _____

Information should be sent to:
Sobhan Namvar, LICSW
32 N. Main St.
Andover MA 01810
617-642-7274
Snam **@andoverps.net**

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the community support coordinator, named above.
- I may refuse to sign this authorization. In this case no communication, specific to my case, will be allowed with community support services and other treatment providers.
- Information releases on this authorization, if redisclosed, by the recipient, are not protected by community support services.
- This release will expire 90 days from the date below, 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 or Client's representative: Please make sure that all appropriate sections above are completed before signing this authorization. Do <u>not</u> sign a blank authorization form.

_____ _____
Signature of client (if 18 or older);
Or parent (if client in under 18);
Or Legal Guardian; or Health care Agent (circle one)

Signature of Witness (clinician/ or intern)

_____ _____ _____ _____
Client Name/ or Authorized Person **Date** **Print Name of Clinician/ or intern** **Date**