Hazel Approach Psych Services
1214 Park St, Suite 201B, Stoughton, MA 02072
DrSasheen@HazelApproach.com
Phone: 617-631-8754 Fax: 617-860-4082

Authorization to Obtain Confidential/Protected Health Information

Patient Name: _____ Date of Birth: _____

I authorize Dr. Sasheen Hazel of Hazel Approach Psychological Services to obtain from the following Contact:

Name: _____

Address: _____

Phone: _____

Relationship of Contact to the Patient: _____

Any individually identifiable health information collected, created or maintained by the above named provider pertaining to my prognosis, diagnosis, or treatment: Information to be released includes:

☐ Assessment _____ ☐ Mental Health Diagnosis _____ ☐ Treatment Plan _____

☐ Psychiatric Evaluation _____ ☐ Discharge Summary _____

☐ Other Mental Health Treatment Information _____

☐ Other Information _____ (*specified here:*_____)

For date(s) of service: _____

Method of release: ☐ Telephone/Verbal ☐ Photocopies ☐ Fax/ Secure Email

☐ Case Conference/Team Meeting ☐ Other (specify): _____

I understand that the release of this information is to coordinate support for all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided by those recipients to Hazel Approach Psychological Services only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature: _____ Date: _____

If patient is under 18 years of age:

Signature Parent/Guardian: _____ Date: _____