**Bill (Wm D) Slaughter MD MA**
**(617) 233-8957**

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## *Authorization to obtain, use, disclose protected health information*

Patient:
Name DOB SSN
Address Phone

For medical care, I authorize Dr Slaughter and to communicate

regarding my protected health information for the treatment period of

Specific information to obtain from/disclose:

Specific information *not* to be exchanged is:

This authorization ends: 90 days after signed or ___________________________
or one month after termination of treatment with Dr Slaughter.

By my signature below I authorize Dr W Slaughter to obtain, use and/or disclose my health information within the parameters described above, and that once he discloses any such information as authorized he cannot guarantee further confidentiality. I understand that I can refuse to sign this authorization, or revoke or change it in writing. I understand that any revocation will only serve to be effective prospectively. I have had an opportunity to discuss this authorization with Dr Slaughter, have asked any questions I have at this time and will do so in the future as they arise.

Signature ________________________________ date ____________

***Additional signatures for highly confidential information:*** By signing my name next to (a) specific category(ies) of information below I am specifically authorizing obtaining, using and/or disclosing that type of information meeting the parameters above. This pertains to testing, status and/or treatment regarding:

- ❖ Abuse/neglect/assault (physical, sexual) ______________________
- ❖ HIV/AIDS testing, status or treatment ______________________
- ❖ Medical condition(s):__________________ ______________________
- ❖ Mental illness, behavioral health, or developmental disability ______________________
- ❖ Psychotherapy ______________________
- ❖ Sexually transmitted disease(s) ______________________
- ❖ Substance Abuse/Dependence ______________________

Date:______________________

*Release Nov 22.docx*
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