MAINE BEHAVIORAL HEALTHCARE

AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

IDENTIFICATION (NAME AND DOB)

I hereby authorize ____ its authorized employees or agents
(Individual / Organization making disclosure)
to release information from my health record and speak with relevant persons concerning this information.

Send to (Name and Address): ____

____

Dates of Service: From ________________________________ To________________________________

Specific information to be released:

☐ Discharge Summary ☐ Psychiatric Evaluation ☐ Progress Notes
☐ Medical H & P ☐ Medical Consultation ☐ Medication Information
☐ Diagnostic Tests ☐ Doctors Notes ☐ Treatment Plan
☐ Assessment ☐ Crisis Response ☐ Statements by Patient
☐ Other Records – specify ____

I DO authorize the disclosure of any information relating to the diagnosis or treatment of **ALCOHOL or DRUG ABUSE**. If I authorize the release of this information, I understand that such information cannot be redisclosed by a recipient without my specific consent.	I DO NOT: _______ (initial here).
I DO authorize the disclosure of information which relates to **HIV** test results, infection status or treatment information.	I DO NOT: _______ (initial here)
I DO authorize the disclosure of any information relating to the diagnosis or treatment of **MENTAL HEALTH**.	I DO NOT: _______ (initial here).
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released.	I DO: ______ (initial here). I understand that such review must be supervised.

This disclosure is for the purpose of:
☐ Ongoing Treatment / Aftercare
☐ To coordinate treatment efforts with family / concerned others
☐ At the request of the individual client/patient
☐ Other – specify: ____

I understand that:

- I can refuse to disclose some or all of the health care information in my treatment records, but that refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written notice to the Health Information Management Department except to the extent that the action has already been taken in reliance upon it.
- I can cross out any provision on this form with which I disagree.
- If information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be redisclosed by the person or entity that receives this information.
- I understand that I am entitled to a copy of this authorization, upon request.

This authorization is effective for one year from the date of signing. I authorize future disclosures to the same individual and/or entities during this time period.

________________________________ ________________________
Signature of Patient Date

________________________________ ________________________
Signature of Legally Authorized Representative Relationship and Date

________________________________ ________________________
Printed Name of Authorized Representative Witness and Date

Information Released

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Date Released: _________

Initials: ___________

Office Use

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