Health Affiliates Maine

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client Name:_____ DOB:_____ Date:_____

I, _____, hereby authorize
Client/guardian

☐ Clinician
☐ Case Manager
☐ Medication Manager

Provider: _____
at Health Affiliates Maine
_____
_____

To RECEIVE the following information:	**To DISCLOSE the following information:**
(Please check the appropriate box(es))	*(Please check the appropriate box(es))*
❒ Demographics ❒ Assessment ❒ Progress Notes ❒ Treatment Plan ❒ Discharge Summary ❒ Verbal Communication ❒ Other (please specify) _____ _____	❒ Demographics ❒ Assessment ❒ Progress Notes ❒ Treatment Plan ❒ Discharge Summary ❒ Verbal Communication ❒ Other (please specify) _____ _____

Information to be RECEIVED FROM/DISCLOSED TO:

Name:_____ Company: _____

Address: _____

The purpose of this release is:

❒ Coordination of services ❒ Obtain records ❒ Determine eligibility for services
❒ Legal purposes ❒ ISP/ITP planning
❒ Other (please specify) _____

If I have been diagnosed or treated for any of the following, I understand that Health Affiliates Maine needs my specific consent to disclose related information. In no event may any such information, if applicable, be disclosed without my specific consent.

I DO ❒ *DO NOT* ❒ authorize disclosure of information which refers to treatment of diagnosis of drug or alcohol abuse (Federal drug & alcohol regulations, 42 CFR 2.31). Such information may not be disclosed by the recipient without my specific written consent.

I DO ❒ *DO NOT* ❒ authorize release of any information that may relate to diagnosis/treatment for HIV, ARC, or AIDS.

I DO ❒ *DO NOT* ❒ authorize release of any information that may relate to mental health treatment.

I authorize the above-named provider to make subsequent disclosures to the same recipient pursuant to this authorization. **Unless earlier revoked, this consent expires in 90 days or on the following date not to exceed one (1) year.**

Specified Date: _____

I understand that the above information may be covered by the rules of the Department of Health and Human Services (the "Rights of Recipients of Mental Health Services" or the "Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment").

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse consequences. The provider will not condition treatment on signing this authorization, unless the health care is solely for purpose of creating the information listed above for the person listed above.

Revised 4/1/2014

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION (continued)

Client Name: _____ Date: _____

Information to be RECEIVED FROM/DISCLOSED TO: _____

Per company policy, Health Affiliates Maine will NOT release information created by other practitioners or facilities. Statements added to records by clients and/or guardians will not be released without written consent.

I waive my right to review this information prior to its disclosure: ❒ Yes ❒ No

I authorize the provider to send/receive these records by fax: ❒ Yes ❒ No FAX#_____

I acknowledge that I have been offered a copy of this authorization: ❒ Yes ❒ No

I understand that I may cross out any words on this form with which I disagree, and that I may revoke this authorization at any time by written request.

I understand that the information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, may no longer be protected by federal privacy laws.

I understand the matters discussed on this form. I release the Provider, its employees, officers, and medical staff, and business associates from any legal responsibility, or liability for the disclosures of the above information to the extent indicated and authorized herein.

Signatures:

Client _____ Date _____

Authorized Representative _____ Date _____

Relationship to Client _____

Witness _____

** * * Request to Revoke Statement below. * * **

* * * Request to Revoke * * *

I understand that I may revoke this authorization at any time by giving written or verbal notice to Health Affiliates Maine using this form or any other written statement. This will not affect information released prior to receiving my request to revoke. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

My signature below officially revokes this authorization:

Client _____ Date Revoked _____

Authorized Representative _____ Date Revoked _____

Relationship to Client _____

Witness _____