Maine Behavioral Health Organization
49 Oak St Augusta, ME 04330 P: 888-922-4736 F: 844-331-2315

Authorization to Release Information

Name: _____ **DOB:** _____ **SSN:** _____

I hereby authorize ***Maine Behavioral Health Organization*** **To DISCLOSE to __OR To OBTAIN from__ / __Written/Records __Verbal (if checked, a copy of WRITTEN/PAPER RECORDS IS REQUESTED to be sent by electronic means or sent to the above address).**

Name of Person or Organization: _____ Address: _____

Fax#_____ Telephone Number for Verification: _____

INFORMATION TO BE DISCLOSED

Check 'Yes' or 'No' for each of the following and specify the information being requested as needed.

__Yes __No Alcohol and/or drug treatment

Note: Authorization is required to share ANY information about alcohol/drug treatment, whether spoken or written.

__Yes __No Assessments
__Yes __No Crisis/Wellness/Emergency Plans
__Yes __No Discharge Summaries
__Yes __No Laboratory/Diagnostic Reports
__Yes __No Medical History and/or Physicals
__Yes __No Outpatient Treatment
__Yes __No Psychiatric History, Evaluations and/or Medications
__Yes __No Psychological and/or Psychosocial History, Reports, Evaluations
__Yes __No Service/Treatment Plan(s)
__Yes __No Other:_____

PURPOSE FOR DISCLOSURE

Check 'Yes' or 'No' for each of the following:

__Yes __No Ongoing treatment/care management services
__Yes __No Coordination with current treatment provider
__Yes __No Coordination with family/concerned persons
__Yes __No Development of service/treatment/crisis plans
__Yes __No Assistance to obtain government benefits
__Yes __No Eligibility determination entitlements, insurance or employment
__Yes __No At request of individual
__Yes __No Other (Specify):_____
Exceptions: _____

Other exceptions: I understand that the potential for re-disclosure of information by the recipient may occur in certain circumstances, as expressly permitted by federal and/or state law, before formally being admitted, during treatment, and after discharge, without my consent. In general, these circumstances pertain to auditing practices, court orders, harm to self or others, insurance and third party billing, and records subpoenas. I understand that re-disclosures may no longer be protected under HIPAA privacy regulations.

__I DO__I DO NOT authorize disclosure of information that refers to treatment or drug abuse. I understand that it cannot be re-disclosed without my specific consent.

__I DO__I DO NOT authorize disclosure of information which refers to treatment or diagnosis of HIV or AIDS. I understand that some individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, insurance, or social/family relations.

__I DO__I DO NOT wish to review, prior to its release, any information I have authorized for release.

I understand that the information checked is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law, as stated above in the disclosure/exceptions section of this release. I understand that I have the right to review information and material released, except as expressly permitted by law. I understand that treatment or payment cannot be conditioned on my permission to release private information; I do not need to sign this form to receive services and that I may receive a copy of this authorization if I wish. I understand I have the right to revoke this authorization verbally or in writing at any time, unless action on it has taken place. I understand that I may review the organization's *Notice of Privacy Practices* before I sign this form. I hereby release all parties stated herewith from any liability resulting from the release of this information and that copies of this release are as valid as the original. My signature certifies that I have given consent freely and voluntarily and that the benefits, risks, and consequences of releasing or not releasing this information have been explained to me.

_____ _____ _____ _____

Client Signature or Mark Date Witness Signature Date

_____ _____

Guardian/Parent/Legal Representative signature (specify role) Date

This authorization is effective until_____(or one [1] year from client signature date).

REVOCATION OF THIS AUTHORIZATION

_____ _____ _____

Signature/Mark of Person Revoking Authorization Relationship Date

_____ _____ _____

Witness Signature (if Mark/Stamp above) Witness Printed Name Date

Additional Information for Persons/Organizations Receiving either Substance Abuse of Mental Health Information

For Persons/Organizations Receiving Substance Abuse Information:

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you form making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For Persons/Organizations Receiving Mental Health Information:

This information has been disclosed to you from records protected by federal and state confidentiality/privacy laws (Health Insurance Portability and Accountability Act of 1996 (HIPAA- Public Law 104-191), *34-B M.R.S.A subsection 1207; Rights of Recipients of Mental Health Services).* This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

Revised September 9, 2014.