Maine Child Psychology

322 West Road, Belgrade, ME 04917

Telephone: (207) 221-2631 ◆ Fax: (866) 611-6717

MaineChildPsych.com

Authorization to Obtain Protected Healthcare Information

Patient Name:_____ **Date of Birth**:_____

I authorize **Maine Child Psychology** to **obtain copies** of all medical, social, psychological, academic, and other records from providers that **may include but are not limited to** primary care physicians, medical and psychiatric hospitals, birth hospital, case management agencies, Child Development Services, public and private schools, preschools and child care programs, mental health agencies and individual mental health treatment providers and evaluators. Specific agencies or individuals include: ***[Parent or guardian: list specific agencies or provider names, addresses, and dates of service if known]***

Agency/Individual Name	Address	Dates of Service (if known)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Records to be released **may include but are not limited** to inpatient and outpatient hospital or medical center records; history and physical examinations; admission notes; birth records; discharge summaries; medication listings; office notes; educational, developmental and academic testing; psychological, psychiatric, psychosocial, and mental health evaluation and treatment records (including initial assessments, progress notes, treatment plans and discharge summaries); and alcohol or substance abuse evaluation and treatment records

The authorization is valid for records dated from this child's date of birth through the date this authorization is signed.

This information is being requested for this child's evaluation, treatment, and follow-up care.

State and Federal laws require my specific consent to disclose information pertaining to **mental health and substance abuse evaluation and treatment** information. I understand that I may request to review any information in my medical record, and may refuse to disclose some or all of my records. I understand that such refusal may result in improper diagnosis or treatment, denial of insurance benefits, or other adverse effects. ***[Parent or legal guardian: please check the boxes below indicating your understanding and agreement]***

- ❑ I authorize disclosure of information related to treatment or diagnosis or a psychiatric illness/mental health facility information.
- ❑ I authorize disclosure of information related to treatment or diagnosis of drug/alcohol abuse.

I understand that:

- ♦ I can revoke my consent at any time prior to the release of records by delivering a written and dated notice of my wishes to Maine Child Psychology or the agency releasing these records.
- ♦ I can refuse to disclose some or all of my records. ***[Note to parent or legal guardian: please write in or cross out any agencies or specific records or types of records listed on this authorization form that you do not want released.]***
- ♦ Persons having legal parental or guardian rights for this child may obtain a copy of evaluation or treatment records without my written consent.
- ♦ I may have a copy of this authorization to release protected healthcare information form upon request.

By signing this authorization to release protected healthcare information form, I also understand and authorize the staff of **Maine Child Psychology** to:

- ♦ Notify the individual or agency that referred this child for services and my child's primary care provider/physician of the status of the referral and any appointments, including notification if I choose not to schedule an appointment or fail to keep a scheduled appointment.
- ♦ Leave a telephone or email message at the telephone number(s) or email address(es) I provide, informing me of scheduled appointments and services.

My consent to obtain records is effective for 12 months from the date this authorization is signed, unless otherwise noted

I understand that my records may contain information pertaining to **mental health treatment and/or substance abuse treatment,** and agree to the release of this information by signing below.

_____	_____	_____
Signature of parent or legally authorized representative	Date of signature	Please print your name here