Maine Child Psychology
322 West Road, Belgrade, ME 04917
Telephone: (207) 221-2631 ◆ Fax: (866) 611-6717
MaineChildPsych.com

Authorization to Release Health Care Information

Patient Name: _____ Date of Birth: ____/____/_____

Medical Record Identifier: _____ Telephone: _____

I authorize **Maine Child Psychology** to release my health information to: / obtain my health information from: (check one or both boxes for each listed individual or agency)

1. ☐ release ☐ obtain records:_____
2. ☐ release ☐ obtain records:_____
3. ☐ release ☐ obtain records:_____
4. ☐ release ☐ obtain records:_____
5. ☐ release ☐ obtain records:_____
6. ☐ release ☐ obtain records:_____

***Please specify applicable dates*:** From ____/____/_____ to ____/____/_____ or ☐ **all service dates**

Please specify information to be released: ☐ **psychological evaluation** ☐ **release all records**, or list:

_____

_____

I release the above information for the purpose or purposes of:

☐ Ongoing treatment/aftercare

☐ Legal proceeding/Insurance matter: Name of attorney/Insurance Company:_____

☐ Release is to the requesting individual for their own records/use

☐ Other: _____

I understand that:

- ❖ If I received substance abuse or mental health treatment or a referral for such treatment from a health care practitioner or facility other than a substance abuse program or a licensed mental health facility, information about the substance abuse or mental health treatment I received from such practitioner or facility may be disclosed pursuant to my authorization to disclose general health care information.
- ❖ Signing this authorization is not a condition to treatment, payment, enrollment, and eligibility for benefits.
- ❖ I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage, or a claim for health benefits or other insurance or other adverse consequences.
- ❖ I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated, and signed notification or I can make an oral statement revoking this authorization to the facility indicated above except to the extent that Maine Child Psychology staff have already acted in reliance on it.
- ❖ I am entitled to a copy of this authorization, upon request.

- ❖ Information disclosed pursuant to this authorization may be redisclosed by the recipient and therefore no longer protected by the privacy laws.
- ❖ I can cross out any provision on this form with which I disagree.
- ❖ Subsequent disclosures may not be made pursuant to the same authorization unless authorized by me.
- ❖ All records are maintained according to state regulatory guidelines. Some older records may not be available for release that are beyond retention periods.
- ❖ Maine law allows reasonable fees to be collected for copies of medical records which may not exceed processing costs.

State and Federal laws require your specific consent to disclose any of the following types of information (*check the boxes next to the disclosures you wish this authorization to include):*

☐ **I authorize the disclosure of <u>substance abuse program information</u> contained in my medical records.** ***Check this box if you wish this authorization to authorize the disclosure of information maintained by a substance abuse program, substance abuse medical practitioner, or substance abuse unit within a general medical facility from which you received diagnosis, treatment or referral for alcohol or drug abuse. If you authorize the disclosure of substance abuse program information, such information may not be redisclosed by the recipient of the information unless you provide your written consent or such re-disclosure is otherwise permitted by 42 C.F.R. Part 2.***

☐ **I authorize the disclosure of <u>mental health facility information</u> contained in my medical records.** ***Check this box if you wish this authorization to authorize the disclosure of mental health information maintained by a licensed mental health treatment facility, including a mental health unit of a hospital.***

Initial here if you wish to review your mental health facility information prior to its disclosure _____

☐ **I authorize the disclosure of <u>HIV (Human Immunodeficiency Virus) information</u> contained in my medical records.** ***Check this box if you wish this authorization to include the disclosure of HIV test results and medical records containing information related to HIV infection status or AIDS (Acquired Immune Deficiency Syndrome). If you check this box, you should understand that persons who have disclosed HIV information have encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.***

This authorization is effective until: ____/____/_____ (date not to exceed one (1) year). The one year limit applies to records dated on or before the date indicated below, or records of services dated on or before the date indicated below. Records or services provided after this date require a new authorization form to be completed.

_____ ____/____/_____
Signature of Patient Date

_____ _____
Signature of Authorized Representative Relationship

THIS RELEASE MUST BE FILLED OUT COMPLETELY - PLEASE READ CAREFULLY

This section for use by Maine Child Psychology

Date Received: ____/____/_____

Date sent ____/____/_____ Information Sent: By Whom:

Date sent ____/____/_____ Information Sent: By Whom:

Date sent ____/____/_____ Information Sent: By Whom: