Client’s Name      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB      \_\_\_\_\_\_\_\_\_\_\_\_\_ SSN      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize  Dorothea Dix Psychiatric Center, PO Box 926, 656 Bangor Street, Bangor, ME 04402

Riverview Psychiatric Center, 250 Arsenal Street, 11 State House Station, Augusta, ME 04332

|  |  |
| --- | --- |
| To: | Client may check  either, or both options |
| Disclose Information To…: |  |
| Obtain Information From …: |  |

This Person or Organization: Maine State Police-Special Investigations Unit

Address: 164 State House Station, Augusta, ME 04333-0164

Fax #: 207-287-3424 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number to verify receipt of information: 207-624-7210

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Include fax number and phone number ONLY if fax is being used to transmit information)

|  |  |  |  |
| --- | --- | --- | --- |
| **Information to Be Disclosed and/or Obtained** | | | |
| Check YES or NO for each of the following: | |  | |
| YES  NO | Alcohol and/or Drug Treatment – (Authorization is required to share ANY information about alcohol/drug treatment, whether spoken or written) | YES  NO | Locus Report |
|  |  | YES  NO | Medical and/or Physical History |
| YES  NO | Any reference to or information about alcohol or other drugs | YES  NO | Outpatient Treatment |
| YES  NO | Assessments / Consultations | YES  NO | Physical Therapy (PT and/or Occupational Therapy (OT) |
| YES  NO | Treatment Plan / Crisis Plans / Emergency Services | YES  NO | Physician Orders, including Medical Index |
| YES  NO | Discharge Summaries | YES  NO | Progress Notes |
| YES  NO | Face Sheet | YES  NO | Psychiatric History, Evaluations, DSM |
| YES  NO | Goold Assessment(s) | YES  NO | Psychological and/or Psychosocial History, Reports, Evaluations |
| YES  NO | Legal / Financial | YES  NO | Social History (Recent and/or Developmental |
| YES  NO | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Purpose for Disclosing and/or Obtaining** | | | |
| YES  NO | Assistance to obtain government benefits | YES  NO | Development of Service / Treatment / Crisis Plans |
| YES  NO | At the request of the Individual | YES  NO | Eligibility determination entitlements, insurance or employment |
| YES  NO | Coordination with family / concerned persons | YES  NO | Ongoing treatment / care management plans |
| YES  NO | Other (specify) Investigative Assistant License | | |

**Initials: \_\_\_\_\_\_\_\_\_\_**

**Please *INITIAL* and *CIRCLE* Your Response to EACH of the following statements:**

\_\_\_\_\_\_\_\_\_\_ I DO \_\_\_\_\_\_\_\_\_\_ I DO NOT …..authorize disclosure of information that refers to treatment or diagnosis of alcohol or drug abuse. I understand that it cannot be re-disclosed without my specific consent.

\_\_\_\_\_\_\_\_\_\_ I DO \_\_\_\_\_\_\_\_\_\_ I DO NOT …..authorize disclosure of information that 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 indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released. I understand I have the right to revoke this authorization in writing at any time. I understand that I do not need to sign this form to receive services and that I may receive a copy of this authorization if I wish. 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**      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date not to exceed one [1] year) |

|  |
| --- |
| **Revocation of this Authorization**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature or 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 or 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 from 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 State confidentiality laws (34-B M.R.S.A. §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.