STATE OF MAINE - Department of Health and Human Services (DHHS)

Client Authorization to Release Information Specifically for:
Dorothea Dix Psychiatric Center or Riverview Psychiatric Center
Please Print Legibly or Type

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

Address: Division of Weapons and Professional Licensing, 164 State House Station, Augusta, ME 04330

Fax #: 207-287-3424 _____ Phone number to verify receipt of information: 207-624-7216

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	Gould 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) Contract Security Company 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.