KENNEBEC BEHAVIORAL HEALTH

115 MOUNT BLUE CIRCLE, FARMINGTON, ME 04938 - PHONE: (207) 530-3026 - FAX: (207) 248-8538

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name: (first, middle initial, last) ____________________

ID: ____________ Date of Birth: ____________ Phone: ____________

I hereby allow KBH, its approved staff or agents to release my Protected Health Information as outlined below.

(Check all approved items)
- ☐ Give, Get and Discuss Records and Information with:
- ☐ Get Records and Information From:
- ☐ Give Records and Information To:
- ☐ Discuss Records and Information With:

Organization/Primary Contact: ____________________

Relationship: ____________ Phone: ____________ Fax: ____________

Address: ____________________

(A) The period for which information is requested is From: ____________ To: ____________

(B) The specific information to be released is: ☐ All information below

- ☐ Discharge Summary
- ☐ Lab Reports
- ☐ Medications
- ☐ Treatment History
- ☐ DSM Diagnosis
- ☐ Psychiatric Evaluation(s)
- ☐ Medical Hx/Physical
- ☐ Treatment Plan(s)
- ☐ Initial Evaluation/Assessment
- ☐ Psychological Assessment(s)/Testing
- ☐ Progress Notes
- ☐ Other: ____________________

(C) The reason for the release of this information is:

- ☐ Assist with Evaluation/Assessment
- ☐ Treatment Planning
- ☐ Judicial Proceedings
- ☐ Coordination of Services
- ☐ Other: ____________________

(D) If I have been diagnosed or treated for any of the following, I understand that my specific consent to disclose related information is necessary. (Must pick an option for each of the three questions below.)

I ☐ Do ☐ Do Not	authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific written consent.
I ☐ Do ☐ Do Not	authorize disclosure of information which refers to mental health/psychiatric treatment or diagnosis.
I ☐ Do ☐ Do Not	authorize disclosure of information that refers to treatment or diagnosis of HIV.

(E) ☐ I wish to look at the information before it is released. This review must be documented.

(F) ☑ I agree to the future release of information to the above person/organization during the approved time period.

(G) This agreement to release information has an **Expiration Date of:** ____________. This date can be no longer than 12 months.

I understand that:

- I can take back this approval at anytime by making a request in writing to KBH Record Room or my service provider at KBH. Stopping this Release of Information will not affect any information released before I took away my approval. Taking away my approval to release records could result in improper diagnosis, improper treatment, and denial of insurance coverage or have other negative consequences.
- I can refuse to release some or all of my records. However, such refusals may result in improper diagnosis, improper treatment, and denial of insurance coverage or have other negative consequences.
- KBH cannot control people or organizations receiving this information to prevent re-release of it without my approval.
- I can cross out any checked off item I do not agree with. I may have a copy of this form upon request.

SIGNATURE: ____________________ DATE: ____________

Client/Guardian or Other Authorized Person's Signature

WITNESS: ____________________ DATE: ____________

For Persons or Organizations receiving Substance Abuse or Mental Health Information:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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 client (52 FR 21809: 52 FR 41997).

This information has been disclosed to you from records whose confidentiality is protected by State Confidentiality Laws (34 MRSA Section 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.

To take back this approval, complete the revocation section below.

REVOCATION

I understand that it is my right to take back this authorization at anytime. I have been informed of the potential consequences resulting from my taking back this authorization. I further understand that taking back this release will not affect the information already released as a result of my original approval to do so but understand that all future releases of this information will not be allowed after the date below.

Revocation of Authorization: ______________________________ DATE: ____________

Client/Guardian or Other Authorized Person's Signature

Witness Signature: ______________________________ DATE: ____________