

# From Lifespan Family Healthcare, Rebecca E Clark, LMFT,

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## AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION PRIMARY CARE PHYSICIAN

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_ (initials: \_\_\_\_\_), hereby authorize Rebecca Clark, LMFT at Lifespan Family HC

Client/Guardian

To  RECEIVE/  DISCLOSE the following information: (Please check the appropriate box(es) below).

Any and all information relating to my care and treatment.

Only the following information which is checked:

Demographics  Assessment  Progress Notes  Treatment Plan  Discharge Summary

Other \_\_\_\_\_

Information to be RECEIVED FROM/DISCLOSED TO:

Name \_\_\_\_\_ Company: \_\_\_\_\_

Address: \_\_\_\_\_

The purpose of this release is:

Coordination of service  Obtain records  Clinical Consultation

Other (Please specify) \_\_\_\_\_

If I have been diagnosed or treated for any of the following, I understand that Cornerstone Behavioral Healthcare needs my specific consent to disclose related information. In no event may any such information, if applicable, be disclosed without my specific consent. I authorize the above-named provider to make subsequent disclosures to the same recipient pursuant to this authorization. **Unless earlier revoked, this consent expires in 90 days or on the following date not to exceed one (1) year.**

Specified Date: \_\_\_\_\_

I DO  DO NOT Authorize disclosure of information which refers to treatment of diagnosis of drug or alcohol abuse (FDA 42 CFR 2.31). Such information may not be disclosed by the recipient without my specific written consent.

I DO  DO NOT Authorize release of any information that may relate to diagnosis/treatment of HIV, ARC, or AIDS.

I DO  DO NOT Authorize release of any information that may relate to mental health Treatment.

I understand that the above information may be covered by the rules of the Maine Department of Health and Human Services (the "Rights of Recipients of Mental Health Services" or the "Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment").

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse consequences. The provider will not deny treatment on signing this authorization, unless the health care is solely for purpose of creating the information listed above for the person listed above.

• I waive my right to review this information prior to its disclosure  Yes  No

• I authorize the provider to send/receive records by fax  Yes  No

• I acknowledge that I have been offered a copy of this authorization  Yes  No

I understand that I may cross out any words on this form with which I disagree, and that I may revoke this authorization at any time.

I understand the matters discussed on this form. I release the Provider, its employees, officers, and medical staff, and business associates from any legal responsibility, or liability for the disclosures of the above information to the extent indicated and authorized herein.

### Signatures to Release:

CLIENT

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

AUTHORIZED

REPRESENTATIVE: (Parent  Guardian  \_\_\_\_\_

DATE: \_\_\_\_\_

WITNESS

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Rebecca E Clark, LMFT

### Please Sign To Revoke

CLIENT: \_\_\_\_\_ AUTHORIZED REP: (Parent  Guardian  \_\_\_\_\_

DATE: \_\_\_\_\_ WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_ (Rev. 06-27-12 HMJ)