From the office of Lifespan Family Healthcare. REBECCA E CLARK, LMFT

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION. Couples

Client Name: _____ **DOB:** _____

Client Name: _____ **DOB:** _____

I, _____, _____**, hereby authorize Rebecca E. Clark, LMFT at Lifespan Family Healthcare**

Client / Guardian

To ☒ RECEIVE/ ☒DISCLOSE the following information:

(Please check the appropriate box(es)). ☐ Any and all information relating to my care and treatment.

☐*Only the following information which is checked:*

☒ *Other: to exchange information for purpose of enhancing treatment in marital counseling*

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 Heath 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.

CLIENT SIGNATURE: _____ **DATE:** _____

_____ _____

WITNESS SIGNATURE: _____ **DATE:** _____

Signatures to Release: Rebecca E. Clark, LMFT

Please Sign To Revoke

CLIENT SIGNATURE: _____ **AUTHORIZED REP:** (Parent ⌐ Guardian ⌐) _____

DATE: _____ **WITNESS SIGNATURE:** _____