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PENOBSCOT NATION HEALTH DEPARTMENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH, COUNSELING OR DENTAL INFORMATION

Instructions: Each section of this form must be carefully reviewed. Please note incomplete or inaccurately completed forms will not be honored by PNHD.

Patient Name:______________________________ Date of Birth:________ Phone #:______________

I understand that my health, counseling, and dental information are confidential and will not be released without my authorization unless permitted by law. I understand that I have the legal right to refuse authorization to disclose all or some my health, counseling, and dental information, but refusal may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

SECTION 1: Releasing/Requesting Information

By law, providers are required to release the minimum amount of information necessary to carry out the purpose of a release. Use the line beside each document type below to indicate the date or range of dates for information to be disclosed under this release, as appropriate.

I hereby grant my permission for the authorized employees of Penobscot Nation Health Department (PNHD) located at 23 Wabanki Way Indian Island, ME 04468,

IMPORTANT: At least one box in each column MUST be checked:

To **RELEASE** the following information:

- ☐ None
- ☐ Chart Summary
- ☐ Laboratory Results: ______________
- ☐ X-ray Results: ______________
- ☐ Progress Notes: ______________
- ☐ Assessment/Intake Summary: __________
- ☐ Psycho-Social History: __________
- ☐ Treatment Plan/Plan of Care: __________
- ☐ Psychiatric Evaluation/Diagnosis: _______
- ☐ Immunizations
- ☐ Ongoing verbal communication for treatment
- ☐ Other (specify:) ______________________

To **REQUEST** the following information:

- ☐ None
- ☐ Chart Summary
- ☐ Laboratory Results: ______________
- ☐ X-ray Results: ______________
- ☐ Progress Notes: ______________
- ☐ Assessment/Intake Summary: __________
- ☐ Psycho-Social History: __________
- ☐ Treatment Plan/Plan of Care: __________
- ☐ Psychiatric Evaluation/Diagnosis: _______
- ☐ Immunizations
- ☐ Ongoing verbal communication for treatment
- ☐ Other (specify:) ______________________

Information to be **RELEASED TO / OR REQUESTED FROM:**

Name of Person/Organization/Facility: Wabanaki Case Management Division of Cornerstone Behavioral Healthcare

Address: PO Box 1356

City/State/Zip: Bangor ME 04402-1356 Tel#: (207)992-0411 Fax:______________

SECTION 2: Purpose of the above release (*Place a √ by each appropriate option.*) The information and material above may only be used for the following purpose(s):

___Verification of Services ____ Ongoing Service Coordination ____ Treatment/Service Planning

___ Legal Matter(s) ____ Transfer of Care _____ Other(specify):______________________

SECTION 3: Special Consents

I understand that the party listed in Section 1 of this authorization need(s) my specific consent to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment.

I DO authorize the release of any information, which refers to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization **unless I initial here** _______________.

If I authorize the release of this information, I understand that the recipient of such information may not further release this information without my specific consent or unless permitted by law.

I DO authorize the release of any information, which refers to the diagnosis or treatment of MENTAL HEALTH under this authorization **unless I initial here** _______________.

I DO <u>**NOT**</u> wish to review the material indicated, before release **unless I initial here** __________.

**** If I have not initialed, it will be assumed that I do not wish to review the material. ****

I DO authorize the release of any information, which refers to the testing, diagnosis or treatment of HIV/AIDS **unless I initial here** _______________.

I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance and social and family relationships I understand that this authorization will stay in effect unless I later revoke this authorization. I understand that if I authorize the disclosure of this information to my insurance company, information which refers to treatment or diagnosis of HIV infection or AIDS may be disclosed to my current and future insurance companies, health plans, or payers unless I revoke or update this authorization.

SECTION 4: Revocation and Expiration

I have the right to revoke this authorization in writing, or by submitting a Revocation Form at any time. Revocation will not cover information/material released prior to that date, but will prevent further release of information. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

This release will expire on ________________________________.

This release may not exceed a maximum of 1 year.

SECTION 5: Signatures

My signature below indicates that I have read this release form and have had all of my questions answered, if any.

- I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.
- I understand what this form authorizes and consent to the release of information as recorded on this form.
- I authorize the party listed in section1 of this form to make subsequent disclosures to the same recipient pursuant to this authorization.
- I understand that information released by PNHD might be further released by the receiving party noted in section 1, and that if this occurs; PNHD cannot guarantee the protection of this information once disclosed.
- I understand that I have a right to request a copy of this authorization.

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_______________________________ Patient Signature   _______________ Date

_______________________________ Representative*   _______________ Date

*Indicate relationship to client

- ☐ Parent
- ☐ Legal Guardian
- ☐ Other Legally Authorized Representative (specify): ____________________

Revocation of Release:____ Date:________________

This information may have been disclosed to you from records whose confidentiality if protected by Federal Law. State and federal regulations 34-B MRSA § 1207 et seq; 424 S.C. § 290 ee-3 & 42 CFR, part 2.1, Confidentiality of Alcohol and Drug Abuse of Patient Records prohibits you from making further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.