Cornerstone Behavioral Healthcare **Wabanaki, Division of Cornerstone #2**

Annual HIPAA - Signature Page

Client Name:	Client #:
Any Changes to Opening Documentation? ☐ No ☐ Yes, see below:	
Client Name:	Client Address:
Contact Number:	Guardian:
The family or household members, if any, with whom I direct Cornerstone Behavioral Healthcare to share my health care information, are the following: (If not applicable, please note N/A)	
The information that Cornerstone Behavioral Healthcare may share with those persons consists of: (If not applicable, please note N/A)	

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO CORNERSTONE BEHAVIORAL HEALTHCARE FOR SERVICES IF IT IS SELF-PAY OR NOT COVERED BY MY INSURANCE, UNLESS I AM ALSO COVERED UNDER MAINECARE. I ALSO UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR MISSED APPOINTMENTS IF I HAVE NOT NOTIFIED CORNERSTONE BEHAVIORAL 24 HOURS IN ADVANCE. I HEREBY AUTHORIZE CORNERSTONE BEHAVIORAL HEALTHCARE TO FURNISH INFORMATION REGARDING MY DIAGNOSIS AND TREATMENT TO THE ABOVE INSURANCE CARRIERS AND/OR MAINECARE, UNLESS I AM SELF-PAY. I HEREBY AUTHORIZE PERMISSION FOR TREATMENT BY PROVIDERS OF CORNERSTONE BEHAVIORAL HEALTHCARE.

THIS SIGNATURE ACKNOWLEDGES THAT I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE BILLING POLICY, CONSENT, ATTENDANCE POLICY, RIGHTS OF RECIPIENTS, AND DISCLOSURE NOTICE AT CORNERSTONE BEHAVIORAL HEALTHCARE. THIS SIGNATURE ALSO ACKNOWLEDGES THE PERMISSION TO TRANSPORT IF APPLICABLE AS WELL AS RELEASING CORNERSTONE BEHAVIORAL HEALTHCARE FROM LIABILITY IN CASE OF AN ACCIDENT DURING ACTIVITIES RELATED TO CORNERSTONE BEHAVIORAL HEALTHCARE, AS LONG AS NORMAL SAFETY PROCEDURES HAVE BEEN TAKEN.

Signatures: If Service is Substance Abuse child must sign.		
Client(14 years & older):		Date:
Authorized Rep:	Relationship to Client:	Date:
Witness:		Date:
I have been offered a copy of any and all of this paperwork. ☐ Yes ☐ No		

Right to Revoke (Disclosure Notice Only)

I understand that I may revoke this authorization at any time by giving written notice of revocation to Cornerstone Behavioral Healthcare; however, this will not affect information released prior to receiving my statement. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

Client(14 years & older):		Date Revoked:
Authorized Rep:	Relationship to Client:	Date Revoked:
Witness:		Date Revoked:

#9

Wabanaki, division of Cornerstone Behavioral Health
157 Park Street, Suite 5 Bangor, Maine 04401
Phone: (207) 992-0411 Fax: (207) 907-2048

Diagnostic Sheet

Client Name:	**DOB:**
Diagnosis	**ICD 10 Code**
Primary	

Diagnosed By:	**Date:**
Supervisor Signature (if applicable):	**Date:**

Cornerstone Behavioral Healthcare Wabanaki, Division of Cornerstone #11

AC-OK Screen for Co-Occurring Disorders – Adolescent (10-21)

(Mental Health, Trauma Related Mental Health Issues & Substance Abuse)

Client Name (print):	**Client#**
DOB:	**Date of Service:**

During the past year, have you:	
1. Felt really sad, lonely, hopeless, stopped enjoying things, wanted to eat more or less, had problems sleeping, or doing what you need to at home or at school?	☐yes ☐no
2. Heard voices or seen things that others don't hear or see?	☐yes ☐no
3. Burned or cut yourself?	☐yes ☐no
4. Been prescribed medication for your feelings?	☐yes ☐no
5. Tried to kill yourself?	☐yes ☐no
6. Had thoughts about hurting yourself or wanting to die?	☐yes ☐no
	Number of 'yes' 1-6:
7. Been in trouble with the law, school, parents, or lost friends because of your drinking alcohol or using other drugs, and continued to use?	☐yes ☐no
8. Drunk alcohol or used other drugs to change the way you feel?	☐yes ☐no
9. Drunk alcohol or used other drugs more than you meant to?	☐yes ☐no
10. Changed your friends or planned your free time to include drinking alcohol or using other drugs?	☐yes ☐no
11. Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using?	☐yes ☐no
12. Tried to stop drinking alcohol or using other drugs, but couldn't?	☐yes ☐no
	Number of 'yes' 7-12:
13. Have you experienced a very bad thing happen (a traumatic event) where you continue to feel scared, worried, nervous, or even had nightmares that bothered you after it was all over?	☐yes ☐no
14. Have you ever been afraid of your parent, caretaker, or a family member?	☐yes ☐no
15. Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone?	☐yes ☐no
	Number of 'yes' 13-15:

Client Signature:
Provider Signature:
Provider Printed Name & Credentials:

Must be completed at intake and renewed yearly.

Cornerstone Behavioral Healthcare **Wabanaki, Division of Cornerstone** **#12**

Case Management ISP Signature Page

Client#

Client Name:
Date of Plan:
Type of Plan: ☐Initial ☐Review ☐Other ☐Annual
Is this Review late? ☐Yes ☐No (If yes, answer the following)
• Did the ISP remain in effect? ☐Yes ☐No
• Provide the reason for the review being late: ☐Client cancellations/no shows ☐Client did not return for services ☐Infrequency of client visits ☐Other (please explain):
☐Provider error (please explain):
Address/ Phone Change: ☐Yes ☐No (If yes, update):
List those involved in ISP development: ☐Client ☐Parent/Guardian ☐Case Manager ☐Provider ☐Other:
Is client AMHI Class Member? ☐Yes ☐No (If yes, answer the following)
• Does client have an Advance Psychiatric Directive? ☐Yes ☐No
• If yes, was it reviewed? ☐Yes ☐No
Was the Crisis Plan reviewed? ☐Yes ☐No (If no, answer the following)
• If Crisis Plan was not reviewed, why not?
Domains (The following goal areas should be considered in the context of the individual's recovery. Please check each domain that is an active need to be addressed on this treatment plan, indicate a status and designate a responsible team member)
STATUS KEY: *GE (Goal Established); AN (Assessed, No Need at this time); AO (Assessment On-going); CC (Client Chooses not to address at this time); GA (Goal Achieved); C (Continuing); D (Dissolved): UN (Unmet Need)*

Domain	**Status**
☐ Housing	
☐ Financial	
☐ Education	
☐ Social/Recreation/Peer ☐Family ☐Cultural/Gender ☐Recreational/Social ☐Peer Support	
☐ Transportation	
☐ Health Care ☐Dental ☐Eye Care ☐Hearing Health ☐Medical	

Case Management ISP Signature Page

Client#

☐ Vocation	
☐ Legal	
☐ Living Skills	
☐ Substance Use	
☐ Mental Health ☐Trauma ☐Emotional, Psychological ☐Psychiatric/Medications ☐Crisis	
☐ Spiritual/Cultural	
☐ Outreach	
☐ Other (please specify):	

For all unmet needs listed above, please document the reason and indicate a plan to address these:
Additional Comments:
Risk and Benefits Statement I have developed my ISP and Safety Plan with my provider. We have reviewed the risks and benefits associated with these plans. I have been offered a copy of these plans and agree to work towards these goals. ☐Yes ☐No (If no, please explain):

Client Signature	**Date**
Parent/Guardian Signature	**Date**
Provider Signature/Credentials	
Supervisor Signature (if applicable)	

Cornerstone Behavioral Healthcare Wabanaki, Division of Cornerstone #13

Crisis/Safety Plan

Client Name:	
Client #:	Date:
Emergency Contact Name / Relationship*	Telephone Number

*Is this contact the same as on the Consolidated Demographic? ☐Yes ☐ No (If no, please submit an updated Consolidated Demographic Form.)

What does a crisis look like for you?

What is likely to set off a crisis?

What is Helpful? (Intervention Steps: Call a friend, Listen to music, Write in a journal, Go for a walk, Exercise, Go to sleep, Medication, Call Therapist, Call Crisis)

Who is Helpful?

What is Not Helpful?

Who is Not Helpful?

- Have you ever called a Crisis Program? ☐Yes ☐No ☐Does not apply
- Have you ever been in a crisis unit? ☐Yes ☐No ☐Does not apply
- Would you be interested in having a meeting with a crisis worker in your area to develop a new crisis plan? ☐Yes ☐No ☐Does not apply
- Do you have a crisis plan on file at your local crisis contractor? ☐Yes ☐No ☐Does not apply

Important Telephone Numbers	
STATEWIDE CRISIS: 1-888-568-1112	**LOCAL POLICE : 911**
STATE POLICE: 1-800-482-0730	**LOCAL FIRE: 911**
POISON CONTROL: 1-800-442-6350	**OTHER:**

Other Information: (Included telephone number if applicable)

Client Signature:	Date:
Parent/Guardian Signature:	Date:
Case Manager Signature:	Date:
Supervisor Signature:	Date:
Printed Name and Credentials:	

Cornerstone Behavioral Healthcare
157 Park St. Suite 5
Bangor, Maine 04401
Phone: (207) 992-0410 Fax: (207) 992-0414

Wabanaki, Division of Cornerstone
P.O. Box 1356
Bangor Maine 04402
Phone: (207) 992-0411 Fax: (207) 907-2048

PCP Cover Letter

(To be submitted at the first date of service)

Dear: ____ ,
(Primary Care Provider)

Client, _______________________________________ , is currently being
(Client Name)

seen in either our Bangor or Waterville office by, ____,
(Case Manager's Name)

for either Counseling services, Case Management services or Medication Management services.

In an effort to provide integrated services for our client we are requesting current medical

records for coordination of treatment.

If we can be of assistance, please feel free to contact us at:______________________________
(Branch Phone Number)

Attached is a signed release from this client to you.

Sincerely,

Case Management Division
Cornerstone Behavioral Healthcare

Child's Name:	Middle:	Last Name:	Date of Birth (MM/DD/YYYY
Mainecare Number	□ TCM Provider	□ BHH Provider	□ HCT Provider
Start Date:	□ Entry into Service	□ Re Assessment	□ Discharge

Child STRENGTHS (Ages 0-21)

0=Centerpiece Strength 2=identified Strength
1=Useful Strength 3=Not yet identified as a strength

#	Item	0	1	2	3
1	Family Strengths				
2	Interpersonal Skills				
3	Optimism				
4	Educational Setting				
5	Vocational				
6	Talents & Interests				
7	Spiritual/Religious				
8	Community Involvement				
9	Natural Supports				
10	Relationship Permanence				
11	Child/Youth Involvement w/care				
12	Coping & Survival Skills				
13	Resiliency				

Child LIFE FUNCTIONING (Ages 0-21)

0=No Evidence 1= Minimal Needs 2=Moderate Needs 3=Severe Needs

#	Item		0	1	2	3
14	Family Functioning					
15	Living Situation					
16	**SCHOOL/DAYCARE *** → If Score '0' NA	↓	0			
17	School Behavior	NA				
18	School Achievement	NA				
19	School Attendance	NA				
20	Relationships with Teacher/Caregiver	NA				
21	Social Functioning					
22	Recreation / Play, for Young Children					
23	Communication					
24	Physical Health					
25	Sleep					
26	Elimination					
27	Personal Hygiene/Self Care					
28	Gender Identity					
29	**SEXUAL DEVELOPMENT *** → If Score '0' NA	↓				
30	Hyper-Sexuality	NA				
31	Masturbation	NA				
32	Sexually Problematic Behaviors	NA				
33	Knowledge of Sex	NA				
34	Choice of Relations	NA				
35	Pregnancy and Child Bearing	NA				
36	Judgment/Decision Marking					
37	Legal					
38	Independent Living Skills					
39	Job Functioning					
40	**DEV/INT DISABILITY *** → if Score '0' NA	↓				
41	Autism Spectrum Disorder	NA				
42	Cognitive(Intellectual Functioning)	NA				
43	Agitation	NA				
44	Self-Stimulation	NA				
45	Motor	NA				
46	Developmental Delay	NA				
47	Sensory Reactivity	NA				
48	Atypical Behaviors	NA				
49	Failure to Thrive	NA				
50	Eating	NA				
51	Mobility	NA				
52	Positioning	NA				
53	Elimination	NA				

Page Break – EIS Dimension

Child RISK BEHAVIORS (Ages 6-21)

0=No Evidence 2=Recent behavior/causing problems
1=History or sub threshold watch/prevent 3=Acute/ causing severe problems

#	Item	NA	0	1	2	3
54	Self-Injurious Behavior	0-5yrs				
55	Suicide Risk	0-5yrs				
56	Reckless Behavior(Other self-harm)	0-5yrs				
57	**DANGER TO OTHERS *** *If Score '0' or <6 yrs. NA*	0-5yrs				
58	History of Perpetrating Violence	0-5yrs				
59	Frustration Management	0-5yrs				
60	Hostility	0-5yrs				
61	Paranoid Thinking	0-5yrs				
62	Secondary Gains from Anger	0-5yrs				
63	Violent Thinking	0-5yrs				
64	Aware of Violence Potential	0-5yrs				
65	Response to Consequences	0-5yrs				
66	Commitment to Self-Control	0-5yrs				
67	Engagement in Treatment	0-5yrs				
68	**SEXUAL AGGRESSION *** *If Score '0' or <6 yrs NA*	0-5yrs				
69	Relationship	0-5yrs				
70	Physical Force/Threat	0-5yrs				
71	Planning	0-5yrs				
72	Age Differential	0-5yrs				
73	Power Differential	0-5yrs				
74	Type of Sex Act	0-5yrs				
75	Response to Accusation	0-5yrs				
76	Temporal Consistency	0-5yrs				
77	History of SAB towards Others	0-5yrs				
78	Severity of Sexual Abuse as Victim	0-5yrs				
79	Success of Prior Treatment	0-5yrs				
80	Runaway	0-5yrs				
81	**DELINQUENT BEHAVIOR *** *If Score '0' or < 6 yrs. NA*	0-5yrs				
82	Seriousness	0-5yrs				
83	History	0-5yrs				
84	Arrests	0-5yrs				
85	Planning	0-5yrs				
86	Community Safety	0-5yrs				
87	Legal Compliance	0-5yrs				
88	Peer Influences	0-5yrs				
89	Parental Influences	0-5yrs				
90	Environmental Influences	0-5yrs				
91	**FIRE SETTING *** *If Score '0' or <6 yrs. NA*	0-5yrs				
92	History	0-5yrs				
93	Seriousness	0-5yrs				
94	Planning	0-5yrs				
95	Use of Accelerants	0-5yrs				
96	Intention to Harm	0-5yrs				
97	Community Safety	0-5yrs				
98	Response to Accusation	0-5yrs				
99	Remorse	0-5yrs				
100	Likelihood of Future Fires	0-5yrs				
101	Intentional Misbehaviors	0-5yrs				
102	Bullying Others	0-5yrs				
103	Medication Compliance	0-5yrs				

Child BEHAVIORAL EMOTIONAL NEEDS (Ages 6-21)

0=No Evidence 1=watch/prevent 2=causing problem 3=causing severe problems

#	Item	NA	0	1	2	3
104	Psychosis/Thought Disturbances	0-5yrs				
105	Depression	0-5yrs				
106	Anxiety	0-5yrs				
107	Mania	0-5yrs				
108	Impulsivity/Hyperactivity	0-5yrs				
109	Attention/Concentration	0-5yrs				
110	Oppositional Behavior	0-5yrs				
111	Conduct	0-5yrs				
112	Anger Control	0-5yrs				
113	**SUBSTANCE USE*** *If Score '0' or <6 yrs. NA*	0-5yrs				
114	Severity of Use	0-5yrs				
115	Duration of Use	0-5yrs				
116	Stage of Recovery	0-5yrs				
117	Peer Influences	0-5yrs				
118	Parental/Caregiver Influences	0-5yrs				
119	Environmental Influences	0-5yrs				
120	Eating Disturbances	0-5yrs				
121	Attachment Difficulties	0-5yrs				

Page Break- EIS Dimension

Caregiver RESOURCES AND STRENGTHS (Ages 0-21)

0=No Evidence 1=Minimal Needs 2= Moderate Needs 3=Severe Needs

#	Item		0	1	2	3
122	Supervision					
123	Involvement with Care					
124	Knowledge of Child's Needs					
125	Organizational Skills					
126	Social Resources					
127	Residential Stability					
128	Physical Health					
129	Mental Health					
130	Substance Use					
131	Post Traumatic Reactions					
132	Developmental					
133	Access to Child Care					
134	Military Transitions					
135	**FAMILY STRESS*** → **if Score '0' NA**					
136	Hygiene & Self-Care/Daily Living Skills	NA				
137	Cultural Stress	NA				
138	Employment	NA				
139	Education Attainment	NA				
140	Legal	NA				
141	Motivation for Care	NA				
142	Financial Resources	NA				
143	Transportation	NA				
144	Safety					

MEDICAL (Ages 0-21)

0=No Evidence 1=Minimal Needs 2= Moderate Needs 3=Severe Needs

#	Item		0	1	2	3
145	**MEDICAL HEALTH *** → **if Score '0' NA**					
146	Life Threatening	NA				
147	Chronicity	NA				
148	Diagnostic Complexity	NA				
149	Emotional Response	NA				
150	Impairment in Functioning	NA				
151	Intensity of Treatment	NA				
152	Organizational Complexity	NA				
153	Family Stress	NA				

INFANT AND CHILDREN (Ages 0-5)

0=No Evidence 1=watch/prevent 2=causing problem 3=causing severe problems

#	Item	NA	0	1	2	3
154	Self-Harm	6-21yrs				
155	Aggressive Behaviors	6-21yrs				
156	Intentional Misbehaviors	6-21yrs				
157	Sexually Reactive Behaviors	6-21yrs				
158	Bullying Others	6-21yrs				
159	Fire Setting	6-21yrs				
160	Flight Risk	6-21yrs				

Child RISK FACTORS (Ages 0-5)

0=No Evidence 1=watch/prevent 2=causing problem 3=causing severe problems

#	Item	NA	0	1	2	3
161	Birth Weight	6-21yrs				
162	Prenatal Care	6-21yrs				
163	Labor and Delivery	6-21yrs				
164	Substance Exposure	6-21yrs				
165	Parent or Sibling Problems	6-21yrs				
166	Paternal Availability	6-21yrs				

Child FUNCTIONING/DEVELOPMENT (Ages 0-5)

0=No Evidence 1=watch/prevent 2=causing problem 3=causing severe problems

#	Item	NA	0	1	2	3
167	Motor	6-21yrs				
168	Eating	6-21yrs				
169	Sensory Reactivity	6-21yrs				

Child BEHAVIORAL EMOTIONAL NEEDS (Ages 0-5)

0=No Evidence 1=watch/prevent 2=causing problem 3=causing severe problems

#	Item	NA	0	1	2	3
170	Attachment Difficulties	6-21yrs				
171	Emotional Control(Temperament)	6-21yrs				
172	Failure to Thrive	6-21yrs				
173	Depression	6-21yrs				
174	Anxiety	6-21yrs				
175	Atypical Behaviors	6-21yrs				
176	Impulsivity/Hyperactivity	6-21yrs				
177	Oppositional Behavior	6-21yrs				
178	Eating Disturbances	6-21yrs				

Child STRENGTHS (Ages 0-5)

0= Centerpiece Strength 1- Useful 2= Identified 3= Not yet identified

#	Item	NA	0	1	2	3
179	Persistence	6-21yrs				
180	Curiosity	6-21yrs				
181	Adaptability	6-21yrs				
182	Interpersonal/Social Behavior	6-21yrs				

ADVERSE CHILDHOOD EXPERIENCES (ACES) (Ages 0-21)

#	Item	No	Yes
183	Sexual Abuse		
184	Physical Abuse		
185	Emotional Abuse/Neglect		
186	Physical Neglect		
187	Domestic Violence		
188	Parental Incarceration		
189	Household Substance Exposure		
190	Family History of Mental Illness		
191	Disruption of Caregiving		

TRAUMATIC STRESS SYMPTONS (Ages 0-21)

0=No Evidence 1= Minimal Needs 2= Moderate Needs 3= Severe Needs

#	Item	0	1	2	3
192	Adjustment to Trauma				
193	Traumatic Grief/Separation				
194	Re-Experiencing				

Authorization to Release Information

A

We are committed to the privacy of your information.
Please read this form carefully.

Which DHHS office(s) should help you? Please check**.**

❒Office of MaineCare Services	❒ Substance Abuse and Mental Health Services
❒Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:

Whose information is being released? Please print clearly.

Individual's Name	Date of Birth	Social Security #
Home Address	Town/City	State Zip Code
Telephone ( ) -	Email address @	

What information should DHHS release? Please check all that apply.

General permission: ❒**All** health information from the DHHS office(s) checked above ❒Claims or encounter data (information about visits to health care providers) ❒Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits ❒Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2017" or "Claims from 2015-2017") ____ ❒Other:____	**Special permission**: **Drug/Alcohol Referral or Services** ❒Include **all** drug/alcohol information in the release ❒Include only the **specific** drug/alcohol records checked: ❒Diagnosis and treatment ❒Clinical notes and discharge summaries ❒ Drug/Alcohol history or summary ❒Payment or claims information ❒Living situation and social supports ❒Medication, dosages or supplies ❒Lab results ❒Other: __________________________________
Special permission: Mental/Behavioral Health Services ❒Include this information in the release ❒I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. **Please note**: Maine law allows us to share this information with other health care providers and health plans to coordinate your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ❒Include this information in the release **Please note**: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if your data is misused. **DHHS** will protect your HIV data, and all your information, as the law requires.

Are you asking DHHS to send your information by EMAIL? ❒ Yes.

Although DHHS has privacy and security protections for my information, I understand that email and the internet have risks that DHHS cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask DHHS to send my information by email**. INITIAL HERE** _______
Where should DHHS send your information by email? Please print the email address clearly:

What is the purpose of the release? Please check or write a response.

❒ **To coordinate or manage my care** ❒ **For a legal matter, including to provide testimony**
❒ **A personal request** ❒ **To see if I qualify for benefits or insurance** ❒ **Other** ______________________________

Please check and print clearly below: ❒Send my information to ❒Get my information from:

Name Wabanaki Case Management Division of Cornerstone Behavioral Healthcare	Name Wabanaki Case Management Division of Cornerstone Behavioral Healthcare
Address PO Box 1356	Address PO Box 1356
City, State, Zip Code Bangor ME 04402-1356	City, State, Zip Code Bangor ME 04402-1356
Phone (207)992-0411 Fax No.	Phone (207)992-0411 Fax No.

I understand and agree that:

- "Information" may be in written, spoken and/or electronic format.
- This form will expire **one year** from the date below unless I revoke (take back) my permission sooner.
- To take back my permission, I will fill out the Revocation Form found at http://www.maine.gov/dhhs/privacy/index.shtml and send it to the office where I receive services. It will not apply to the information that DHHS already released with my permission.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance coverage.
- I permit the people and/or offices listed on this form to speak to each other for the purpose(s) on this form.
- Health information from other providers (such as doctors, hospitals, and counselors) in my DHHS file is included in this release.
- Unless I am applying for benefits, DHHS will not base my treatment, payment for services, or benefits on whether I sign this form.
- DHHS offices will keep my information confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, DHHS will include a notice saying that such information may not be re-released or shared without my written permission.

I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.

Date: __________**Signature**____

Personal Representative's authority to sign: ____________________________________

C

PENOBSCOT NATION HEALTH DEPARTMENT

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

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

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

<u>I understand that my health, counseling, and dental information are confidential</u> 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 **<u>RELEASE</u>** 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 **<u>REQUEST</u>** 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.

PENOBSCOT NATION HEALTH DEPARTMENT
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH, COUNSELING OR DENTAL INFORMATION

Patient Signature ______________________ Date ______________

Representative* ______________________ Date ______________

*Indicate relationship to client

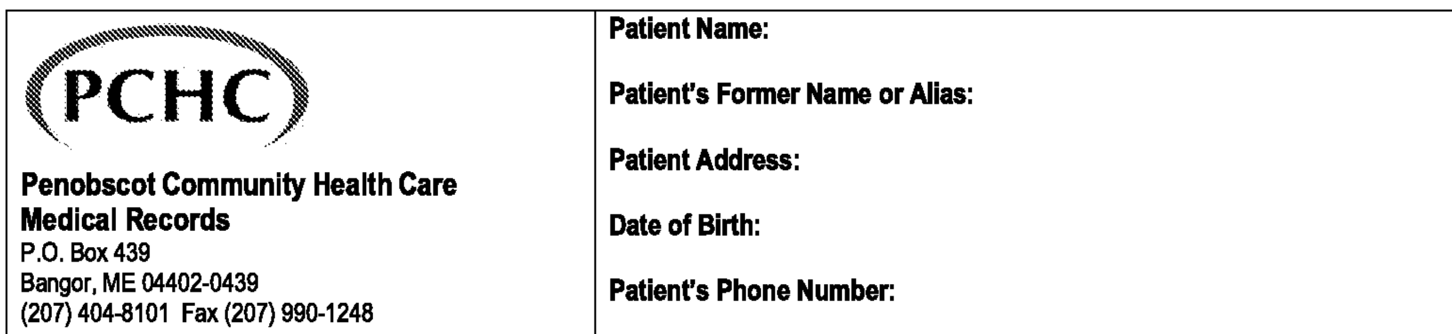
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other Legally Authorized Representative (specify): ______________

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.

Penobscot Nation Health Department 23 Wabanaki Way Indian Island, ME 04468
Phone: 207-817-7400
Fax: 207-817-7453

D



Penobscot Community Health Care Medical Records P.O. Box 439 Bangor, ME 04402-0439 (207) 404-8101 Fax (207) 990-1248	**Patient Name:** **Patient's Former Name or Alias:** **Patient Address:** **Date of Birth:** **Patient's Phone Number:**

Authorization to Disclose Health Information

By signing below, I authorize Penobscot Community Health Care (PCHC) and its staff (*check applicable box(es)*):

☐ To **DISCLOSE** my health information below **TO**: ***AND/OR*** ☐ To **OBTAIN** my health information below **FROM**:

Name of Person or Organization: Wabanaki Case Management Division of Cornerstone Behavioral Health

City/State/Zip Code: P.O. Box 1356 Bangor, Maine 04402-1356

Phone: (207) 992-0411 Fax: (207) 907-2048/ (207) 992-0414

By: ☐ Mail* ☐ Fax ☐ Email** (*specify recipient's email address*: ____________________)

☐ Verbal Communication ☐ other (*specify instructions*): ____________________

** Records provided by mail will be sent on a compact disc, unless you specify other instructions.*

*** Records provided by email will be provided in Adobe PDF files that will be accessible to the email recipient via PCHC's secure messaging portal. An email will be sent to the email address you provide with instructions to the recipient on how to access such records via PCHC's portal.*

Health Information to be Disclosed

☐ My entire medical record (*complete "Sensitive Medical Information" section below if you wish sensitive types of health disclosed*)

☐ My medical records for the following dates: _____/_____/_____ to _____/_____/_____

☐ Only the following specific types of medical records or information for the following dates: _____/_____/_____ to _____/_____/_____

☐ Clinical Records ☐ Immunization Records ☐ Lab Reports ☐ Hospital Records ☐ Radiology Reports ☐ Summary Records

☐ Other Records (specify): ____________________

Unless I strike out this sentence, I intend this authorization to include disclosure of records and information the above disclosing person or organization has received from other healthcare providers, facilities or persons, unless such information may be withheld by law (see note below).

Sensitive Health Information

I specifically intend this authorization to include the disclosure of (*initial all that apply*):

[_____] **Mental and behavioral health records and information**, including (i) records and information maintained by licensed mental health facilities, programs and agencies, and (ii) records and information related to mental health services provided by licensed mental health professionals. *I understand that I have the right to review any mental and behavioral health records maintained by licensed mental health facilities, programs or agencies at any reasonable time before deciding to authorize their disclosure on this form. (Note: licensed mental health facilities, programs and agencies may refuse to disclose information or records they have obtained from another individual or facility through an assurance of confidentiality, though you have the right to receive a summary description of such information.)*

[_____] **Substance use disorder program records and information (subject to protection under 42 C.F.R. Part 2).**

[_____] **HIV (Human Immunodeficiency Virus) / AIDS (Acquired Immune Deficiency Syndrome) information, including HIV test results, HIV/AIDS status, and medical records containing HIV/AIDS information.** *I understand that authorizing the disclosure of HIV/AIDS records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.*

Authorization of Continuing Communications and Subsequent Disclosures

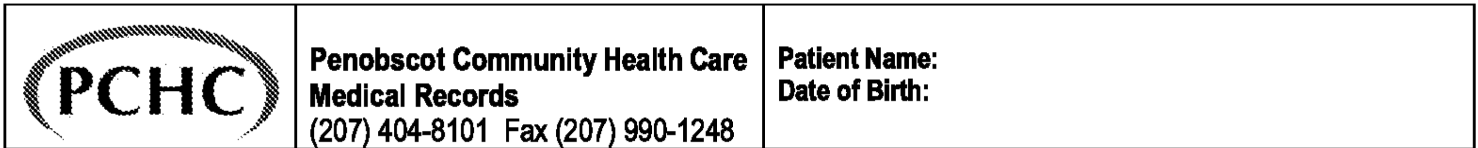
Unless I strike out any of the following, I intend this authorization to authorize continuing communications and subsequent disclosures of information within the scope of this authorization (i.e., the disclosing and recipient parties of my health care information are authorized to have continuing communications concerning the health care information authorized to be disclosed by this form, and to disclose information covered by this authorization that was created or related to clinical encounters occurring after the date of my signature below).

I authorize the disclosure of the above information for the following purpose(s) (check applicable box(es)):

☐ At my request ☐ Treatment or Coordination of Medical Care ☐ Transfer of medical care ☐ Legal Matter or Proceeding

☐ Insurance coverage or payment purposes ☐ Other (specify): ____________________

D


Penobscot Community Health Care
Medical Records
(207) 404-8101 Fax (207) 990-1248

Patient Name:
Date of Birth:

Duration or Expiration Date/Event: This authorization will expire thirty (30) months from the date of my signature below, unless earlier revoked by me or unless I enter an earlier expiration date or event here: ______________________ (date cannot exceed 30 months from date of signature). To the extent that this authorization authorizes disclosure of (i) mental health records and information maintained by a licensed mental health facility, program or agency, (ii) information concerning a child in a licensed residential care facility, or (iii) information concerning a child in a licensed foster care home, that part of the authorization will expire one (1) year from the date of my signature below, unless earlier revoked by me or unless I have entered an earlier expiration date or event in the space above.

By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of some or all the above healthcare information but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying PCHC in the manner described in PCHC's Notice of Privacy Practices (except to the extent that PCHC or any other person has already acted in reliance on it), but that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- PCHC will not condition services or treatment on whether I sign this authorization, unless authorized to do so by law.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I have the right to a copy of this signed authorization.

______________ Date

______________________________ Signature of Patient or Patient's Authorized Representative***

______________________________ Printed Name

Authorized Representative's Legal Authority: ☐ Legal guardian ☐ Health care power of attorney agent ☐ Health care surrogate ☐ Parent of a minor

*** Signature by an authorized representative certifies to PCHC that such person has the legal authority indicated to authorize disclosure of the patient's information and records on behalf of the patient.

FOR OFFICE USE ONLY

If the disclosure is by PCHC and the disclosure is partial or incomplete as compared to the patient's request, PCHC must notify the patient and recipient of the information that the disclosure is partial or incomplete by checking this box: ☐

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

Received by: ______________________ Location: ______________________ Date: ______________

Rev. 03/15/2021
MRC001

E

Patient Identification

Name:

DOB:

☐A.R. Gould Hospital
☐Acadia Hospital
☐Acadia Healthcare
☐Beacon Health
☐Blue Hill Hospital
☐C. A. Dean Hospital
☐Eastern Maine Medical Center
☐Inland Hospital
☐Lakewood
☐Maine Coast Hospital
☐Mercy Hospital
☐Northern Light Home Care & Hospice
☐Northern Light Laboratory
☐Northern Light Medical Transport
☐Northern Light Pharmacy
☐Sebasticook Valley Hospital
☐Work Health

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

	Phone	Fax		Phone	Fax
A.R. Gould Hospital	(207) 768-4175	(207) 768-4060	Lakewood	(207) 873-5125	(207) 861-9967
Acadia Hospital	(207) 973-6100	(207) 973-6822	Maine Coast Hospital	(207) 664-5454	(207) 664-5398
Acadia Healthcare	(207) 973-6100	(207) 973-6822	Mercy Hospital	(207) 879-3373	(207) 822-2469
Beacon Health	(207) 973-5692	(207) 989-1096	Northern Light Home Care & Hospice	(800) 757-3326	(207) 400-8891
Blue Hill Hospital	(207) 374-3458	(207) 374-3971	Northern Light Laboratory	(207) 973-6900	(207) 973-6999
C. A. Dean Hospital	(207) 695-5225	(207) 695-2254	Northern Light Medical Transport	(207) 275-2940	(207) 973-9487
Eastern Maine Medical	(207) 973-7873	(207) 973-7867	Northern Light Pharmacy	(207) 275-3216	(207) 561-4804
Inland Hospital	(207) 861-3150	(207) 861-3158	Sebasticook Valley Hospital	(207) 487-4026	(207) 487-3204

NONDISCRIMINATION STATEMENT: Northern Light Health and its affiliates (Northern Light Health) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. Northern Light Health does not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

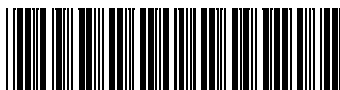
Northern Light Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

  If you need these services, please call 1-888-986-6341. If you have a TTY, you may also dial 711 Maine Relay.

If you believe that Northern Light Health or any of its affiliates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language, you can file a grievance with your Northern Light Health Civil Rights Coordinator, 797 Wilson St., Suite 4, Brewer, ME 04412, 1-866-769-8363 **(telephone),** 1-207-989-1420 **(fax),** or at nondiscrimination@northernlight.org **(email)**. If you need help filing a grievance, your Northern Light Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.



French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-986-6341 (ATS : 711).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-986-6341 (TTY: 711).
Oromo (Cushite): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-986-6341 (TTY: 711).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-986-6341 （TTY：711）。
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-986-6341 (TTY: 711).
Tagalog (Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-986-6341 (TTY: 711).
Cambodian (Khmer): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ *1-888-986-6341 (TTY: 711)*។
Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-986-6341 (телетайп: 711).
Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم *1-888-986-6341* (رقم هاتف الصم والبكم: *711*).
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-986-6341 (TTY: 711).
Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-986-6341 (TTY: 711)번으로 전화해 주십시오.
Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-986-6341 (*TTY:* 711).
Nilotic (Dinka): ***PIŊ KENE****: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-888-986-6341 (TTY: 711)*
Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-986-6341（TTY:711）まで、お電話にてご連絡ください。
Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-986-6341 (TTY: 711).

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I authorize the Northern Light Health entity indicated above to release my health information to:

Name (entity or individual)			Phone
Wabanaki Case Management Division of Cornerstone Behavioral Healthcare			(207)992-0411
Street	City	State	Zip
PO Box 1356	Bangor	ME	04402-1356
Name (entity or individual)			Phone
Street	City	State	Zip
Name (entity or individual)			Phone
Street	City	State	Zip
Name (entity or individual)			Phone
Street	City	State	Zip

NOTE: All disclosures based on this form are limited to records existing at the time the form is signed, unless you (the patient or personal representative) indicate below that you want us to release records related to specific future tests, procedures, appointments, etc.

Indicate the date(s) of service (such as admission date, visit date(s), date range, etc.) (including instructions on release of future records): ____

____

Specific information/documents to be released or comments/instructions (e.g., the particular practice or department from which to release the records):

____

____

PURPOSE: I release the above information for the purpose or purposes of:

☐ On-going treatment/aftercare

☐ Release is to the requesting individual for personal use

☐ Legal proceeding: Name of attorney: ____

☐ Insurance matter: Name of insurance company: ____

This authorization will expire in 12 months unless I give an earlier expiration date here: _________________.

NOTE: for purposes of disclosing information which refers to treatment or diagnosis of HIV infection or AIDS, this authorization will not expire and will remain in effect unless revoked.

Your specific consent is required to disclose any of the following types of information ***(check the boxes only if you want this authorization to include this information)***:

☐ I authorize disclosure of federal drug or alcohol abuse program treatment information contained in my medical records. This information may not be re-disclosed by the recipient without my specific written consent.

☐ I authorize disclosure of information derived from behavioral health services provided by a licensed behavioral health professional. The recipient of this information must be specified by name above.

☐ I want to review my behavioral health information before it is released. I understand this review must be supervised (Northern Light Acadia Healthcare or Northern Light Acadia Hospital patients only).

☐ I authorize the disclosure of information which refers to treatment or diagnosis of HIV infection or AIDS. 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 payors unless I revoke or update this authorization.

I understand that my treatment is not conditioned on signing this authorization. I will not be denied treatment if I do not sign this form. I may review my record before signing. I may refuse to sign this authorization form. Partial or incomplete information will be labeled as such. I understand that, if I refuse to sign this authorization form, it may result in improper diagnosis or treatment, denial of coverage, denial of a claim for benefits, denial of other insurance or other adverse consequences.

I may revoke this authorization at any time except for the information already disclosed. To revoke my authorization, I will submit a written request to the Medical Records Department of the entity indicated above. I understand that, if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage.

I understand that, if this information is disclosed to a third party or to me, the information may no longer be protected by state and federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand that I may have a copy of this authorization form. I decline a copy of this authorization unless I ask for one to be given me.

Signed: ____ Date: __________ Time: ________
(Patient*)

Signed: ______________________________ Relationship: __________ Date: __________ Time: ________
(Authorized Representative*)

*A parent /guardian or other authorized representative is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should sign in addition to their parent/guardian or other authorized representative. If a minor patient consented to his/her own care, the minor patient must sign this authorization form to release records related to that care. Indicate relationship of representative to patient.

st. joseph Healthcare
St. Joseph Hospital
In the Spirit of Healing
Sponsored by Covenant Health Systems
Founded by the Felician Sisters

Patient Name:____________________________
Date of Birth:____________________________
Contact Phone #:____________________________

Written Authorization to Release Copies of Healthcare Information

I the undersigned, hereby authorize St Joseph Healthcare and its designated employees or agents to release/obtain/discuss medical information from my health record.

Where records are now (release from):		**Where records are going (release to):**	
Name:		**Name:**	Wabanaki Case Management Division of Cornerstone Behavioral Healthcare
Address:		**Address:**	PO Box 1356
City, State, Zip:		**City, State, Zip:**	Bangor ME 04402-1356
Phone:		**Phone:**	(207)992-0411
Fax:		**Fax:**	

The purpose of the release is for:

- ☐ Further care
- ☐ Transfer of care *(physician practices only)*
- ☐ Personal records *(i.e. further care; proactive/home file)*
- ☐ Attorney request *(reasonable fee may be assessed)*
- ☐ Other: ____

Date(s) of service – From:____________________ To:____________________

Please specify information to be released:
Physician Reports

☐ Office Treatment Notes ☐ Emergency Department ☐ Psychiatric/Psychological Evaluation
☐ History & Physical ☐ Consultation ☐ Psychosocial Evaluation
☐ Discharge Summary ☐ Operative Report ☐ Assessments/Care Plans/Notes

Diagnostic Reports

☐ Laboratory ☐ Radiology Reports ☐ Radiology Images (CD) ☐ Cardiology ☐ Pathology

Homecare & Hospice Reports

☐ Assessments ☐ Plans of Care ☐ Progress Notes/Summaries ☐ Medication Profiles ☐ Physician Orders

Other information to be disclosed (specify):____
Information that I refuse to disclose (specify):____

If I have been diagnosed or treated for any of the following, I understand that St. Joseph Healthcare needs my specific consent. I do authorize release of this information and waive the right to review records before they are released unless I have specifically initialed under the "I DO NOT" section in the table below.

I **DO** authorize release of information regarding **DRUG AND/OR ALCOHOL ABUSE**. By federal law, such information may not be re-disclosed by the recipient without specific written consent.	**I DO NOT** ________ (initial here)
I **DO** authorize release of information regarding **MENTAL HEALTH** treatment.	**I DO NOT** ________ (initial here)
I **DO** authorize disclosure of information regarding **HIV INFECTION, ARC OR AIDS**. 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, health insurance, and social and family relationships.	**I DO NOT** ________ (initial here)
I **DO** waive the right to review records before they are released. I understand that such review must be supervised.	**I DO NOT** ________ (initial here)

Continued on reverse

F

I understand that my treatment is not conditioned on signing this authorization. I will not be denied treatment if I do not sign this form. I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all such information listed above except those items I have crossed out or specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or claim for health benefits from other insurance(s) or other adverse consequences. Partial or incomplete records will be labeled as such.

If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law (for example, a minor's reproductive health records).

I understand that St. Joseph Healthcare may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I understand that in such cases, I may designate a representative to review my records on my behalf.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand that St. Joseph Healthcare will provide my medical records in the form or format I request (paper or electronic format). If this is not easily able to be produced, it needs to be produced in a machine readable electronic form or format that is agreed upon by myself and St. Joseph Healthcare.

I understand that St. Joseph Healthcare will notify me of its decision to approve or deny my request to access or obtain a copy of the requested information within thirty (30) days of receiving this request. If St. Joseph Healthcare is unable to comply with my approved request for information within thirty (30) days, it may extend the deadline for up to thirty (30) more days by notifying me in writing.

This authorization must be renewed annually. Subsequent disclosures by Releaser are permitted until expiration. However, I understand that I can revoke this Authorization at any time prior to the above time frame, except for the information already disclosed. To revoke my authorization, I will notify the appropriate Health Information Management Department. Such revocation must be in writing, signed, and dated and shall be effective when received, subject to the rights of any such person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis of denial of health benefits, insurance coverage, benefits, and/or other adverse consequences and that I would be responsible for payment for services received.

I understand that I am entitled to a copy of this authorization form.

____ ____________________
Patient Signature **Date & Time**

____ ____________________
Authorized Representative/Relationship **Date & Time**

____ ____________________
Witness **Date & Time**

HOSPITAL USE ONLY

MR#________________________ Processed On:__________________ By:_________________________

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Community Health and Counseling Services

42 Cedar Street
Bangor, ME 04401
(207) 922-4707
Fax: (207) 990-0399

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

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

Client Name:______________________________Case #:_______________ Date of Birth: _____________

I understand that health care information is 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 health care 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 written information to be disclosed under this authorization, as appropriate. Note: CHCS is only able to release information which it has generated.

I hereby grant my permission for the authorized employees or agents of **Community Health and Counseling Services (CHCS)** to release and/or to request the following information:

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

To **RELEASE** the following Information:	To **REQUEST** the following information:
☐ Admission/Intake Summary: ______	☐ Admission/Intake Summary: ______
☐ Assessment/Evaluation Information: ______	☐ Assessment/Evaluation Information: ______
☐ Psycho-Social History: ______	☐ Psycho-Social History: ______
☐ Treatment Plan/Plan of Care: ______	☐ Treatment Plan/Plan of Care: ______
☐ Laboratory/ X-ray Results: ______	☐ Laboratory/ X-ray Results: ______
☐ Medication Record:______	☐ Medication Record:______
☐ Psychiatric Evaluation/ Diagnosis: ______	☐ Psychiatric Evaluation/Diagnosis: ______
☐ Psychiatry Progress Notes: ______	☐ Psychiatry Progress Notes: ______
☐ Discharge Summary/Discharge Orders: ______	☐ Discharge Summary/ Discharge Orders: ______
☐ Progress Notes: ______	☐ Progress Notes: ______
☐ Ongoing verbal communication for treatment and/or discharge planning	☐ Ongoing verbal communication for treatment, and/or discharge planning
☐ Ongoing verbal communication for visitation	☐ Ongoing verbal communication for visitation
☐ Other (specify): ______	☐ Other (specify): ______

I authorize Community Health and Counseling Services to exchange my information with:

Company: (if app.) Wabanaki Health and Wellness

Attention [name]:______________________________

Address: P.O. Box 1356

City/State/Zip: Bangor, Maine 04402-0411 Tel #: (207) 992-0411

SECTION 2: Purpose of the above release *(Place a √ by each appropriate option. At least 1 box MUST be checked.)* **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) ☐ Other *(specify)*: ______________________________

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Client Name:__________________________Case #:_______________ Date of Birth: _____________

SECTION 3: Special Consents

I understand that the party(ies) 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** / ☐ **DO NOT authorize** the release of any information, which refers to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization.

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** / ☐ **DO NOT authorize** the release of any information, which refers to the diagnosis or treatment of MENTAL HEALTH under this authorization.

I ☐ **DO** / ☐ **DO NOT authorize** you to release the material indicated without my reviewing it first.

I ☐ **DO** / ☐ **DO NOT authorize** the release of any information, which refers to the testing, diagnosis or treatment of HIV/AIDS.

SECTION 4: Revocation and Expiration

I have the right to revoke this authorization verbally by speaking with designated CHCS staff or by submitting a Revocation Form (CHCS #3C) at any time. Revocation will not cover information/material released prior to that date but it 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 automatically expire** one year from the date signed (six months for a minor in a residential facility) unless I indicate another date here _______________.
Specify Date or Event

This release may not exceed a maximum of 1-year (six months for minors in residential treatment facilities).

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 understand what this form authorizes and consent to the release of information as recorded on this form.
- I authorize the party(ies) listed in section 1 of this form to make subsequent disclosures to the same recipient pursuant to this authorization.
- I understand that information released by CHCS might be further released by the receiving party noted in section 1, and that if this occurs, CHCS cannot guarantee the protection of this information once disclosed.
- I understand that I have a right to request a copy of this authorization.

______________________________ _______________
Client Signature Date

______________________________ _______________
Representative* Date

*Indicate relationship to client ☐ Parent
☐ Legal Guardian
☐ Other Legally Authorized Representative (specify): ____________________

Cornerstone Behavioral Healthcare **Wabanaki, Division of Cornerstone**

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client #

Client Name: DOB:

I, ☐hereby authorize ☐hereby decline to authorize **(sign at bottom)**

(client/guardian)

to receive or disclose the following information.

(staff or provider name)

Please check the appropriate box(s) below:	
☐	Any and all information relating to my care and treatment.
☐	Only the following information **(please check):** ☐Demographics ☐Assessment ☐Progress Notes ☐Treatment Plan ☐Discharge Summary ☐Other:

Information to be Received from or Disclosed to:	
Name:	Company:
Address:	Phone/Fax:
The purpose of this release is: ☐Coordination of service ☐Obtain records ☐Clinical Consultation	
☐Other (Please specify):	
Specified Date of Expiration:	
I authorize release of any information that may relate to mental health Treatment.	☐Yes ☐No
I authorize release of any information that may relate to diagnosis/treatment of HIV, ARC, or AIDS.	☐Yes ☐No
I 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.	☐Yes ☐No
I waive my right to review this information prior to its disclosure	☐Yes ☐No
I authorize the provider to send/receive records by facsimile	☐Yes ☐No
I acknowledge that I have been offered a copy of this authorization	☐Yes ☐No

*If I have been diagnosed or treated for any of the aforementioned, 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 specified date above, not to exceed one (1) year.** 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 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, 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 Rep ☐Parent ☐Guardian		Date
Witness Signature		Date

Signatures To REVOKE the Receiving or Disclosing of information:

Client Signature		Date
Authorized Rep ☐Parent ☐Guardian		Date
Witness Signature		Date