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Central Aroostook Psych[illegible]: Services LLC
521 Main Street Presque Isle ME 04769
207-764-9700 Fax: 207-764-9703

Patient Name
DOB

CAPS AUTHORIZATION FOR RELEASING/OBTAINING INFORMATION

I agree to allow CAPS to: **RELEASE TO:** ✓ **OBTAIN FROM:** ✓

(Name of person (including relationship to patient) or organization authorized to receive/release information)

(Address) (Telephone)

(Please specify the extent and nature of information to be released or obtained.)

✓ Clinical Diagnosis ___ Progress Notes ✓ Discharge Summary
✓ Psychiatric Evaluation ✓ Treatment Plan ✓ Other labs

The purpose of this release is for: ___ COMMUNICATION & CONTINUITY OF CARE ___

This authorization for releasing/obtaining the above information is to be in effect not to exceed one year (Specify Date: 1yr) unless otherwise revoked.

I understand that my health care provider(s) need my specific consent to disclose information related to any of the following.

1. **Substance Abuse Treatment:** I (DO ✓ DO NOT ___) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse.
2. **Mental Health Records:**
   I (DO ✓ DO NOT ___) authorize disclosure of information which refers to treatment or diagnosis of mental health.
   I (DO ___ DO NOT ✓) want to review such information before it is released. I understand that such reviews must be supervised.
3. **HIV Records:** I (DO ✓ DO NOT ___) authorize disclosure of information which refers to HIV test results, infection status, or treatment information.

I understand that I have the right to:

1. Obtain a copy of this authorization, and to review and copy any information prior to it being released.
2. Review my records and refuse authorization to disclose all or some of the information.
3. Revoke this authorization by written notice to the health care provider at any time, except where the health care provider has already acted upon the authorization.

I understand that such refusal or revocation may result in improper diagnosis or treatment.

I further understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient in the event the information is further disclosed by the receiving party. It may not be protected under federal privacy regulations.

X Patient Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

Revoke Authorization: I hereby revoke this authorization for releasing/obtaining information.
Patient Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____