Cornerstone Behavioral Healthcare Wabanaki, Division of Cornerstone

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

☐ Release for Primary Care Physician Client#: _____

Client Name: _____ DOB: _____

I, _____ ☐ hereby authorize ☐ hereby decline to authorize (Sign at bottom in revoke section)

Client/Guardian

_____ ☐ to receive ☐ to disclose ☐ to receive & disclose

Provider/Staff/Entity Name

Information to be received from or disclosed to:

Name: _____ Company: _____

Address: _____ Email: _____

Phone: _____ Fax: _____

Date Range of information to be received/disclosed: _____

To Receive the following information:
☐ None
☐ Chart Summary
☐ Progress Notes
☐ Assessment/Intake Summary
☐ Treatment Plan/Plan of Care
☐ Laboratory Results
☐ Diagnosis
☐ Billing
☐ Verbal Consent
☐ Only information related to:
☐ Other (specify):

To Disclose the following information:
☐ None
☐ Chart Summary
☐ Progress Notes
☐ Assessment/Intake Summary
☐ Treatment Plan/Plan of Care
☐ Laboratory Results
☐ Diagnosis
☐ Billing
☐ Verbal Consent
☐ Only information related to:
☐ Other (specify):

Expiration Date of Release (if earlier than one (1) year): _____

The purpose of this release is: ☐ Coordination of Service ☐ Obtain Records ☐ Clinical Consultation ☐ Other (Specify):

To release sensitive information, check the applicable box(es) below:
☐ Alcohol/Drug Use Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health Diagnosis & Treatment
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

Client#: _____

I request the provider to send/receive records by: ☐ fax ☐ mail ☐ email

☐ Other: _____

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

I waive my right to review this information prior to disclosure: ☐ Yes ☐ No
(If I **do not** waive my rights, I would like to review the information prior to disclosure)

*If I have been diagnosed or treated for any of the aforementioned, I understand that Cornerstone Behavioral Healthcare (CBH) 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-mentioned provider to make subsequent disclosures to the same recipient pursuant to this authorization. **This consent expires in one (1) year, unless earlier revoked.**
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 "Right of Recipients of Mental Health Services Who Are Children in Need of Treatment"). **Records covered by federal rules governing confidentiality of alcohol and drug abuse treatment programs (FDA 42 CFR 2.31), Records covered by state rules governing mental health services or Records concerning my, or my child's, diagnosis or treatment for HIV or AIDS) require my specific authorization to be disclosed.** I understand that I may refuse to release some or all of the information in the providers 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. I understand that information released by CBH might be further released by the receiving party noted in "Information to be received from or disclosed to", and that if this occurs, CBH cannot guarantee the protection of this information once disclosed.

Signatures to RELEASE:

Client Signature: _____ Date: _____

Authorized Rep: _____ Date: _____
☐Parent ☐ Guardian

Witness Signature: _____ Date: _____

Signatures to REVOKE the receiving or disclosing of information:

Client Signature: _____ Date: _____

Authorized Rep: _____ Date: _____
☐Parent ☐ Guardian

Witness Signature: _____ Date: _____