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

Annual HIPAA - Signature Page

Client Name:	Client #:

Any Changes to Opening Documentation? ☐ No ☐ Yes, see below:

Client Name:	Client Address:
Contact Number:	Guardian:
Email Address:	
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:

Need For Change (NFC)
Self-Rating Scale

6.

Please share with us your opinion about your current education situation

Name: _____ Age:_____ Circle: Male Female Other

Date: _____

Education Level: _____

If you are currently employed, respond to the questionnaire on the LEFT below. If you are currently out of school, respond to the questionnaire on the RIGHT below.

Respond below if you are currently IN SCHOOL First, read each of the 5 statements below. Then, consider which one best describes how you now feel about your education. Finish by placing an X in the box to the left of the statement that best describes how you now feel about your education.	**Respond below if you are currently OUT OF SCHOOL** First, read each of the 5 statements below. Then, consider which one best describes how you now feel about being out of school. Finish by placing an X in the box to the left of the statement that best describes how you now feel about being out of school.
☐ I am Very Dissatisfied with my education, and feel an URGENT NEED to change it.	☐ I am Very Dissatisfied with being out of school, and feel an URGENT NEED to change.
☐ I am Dissatisfied with my education, and feel a STRONG NEED to change it.	☐ I am Dissatisfied with being out of school, and feel a STRONG NEED to change.
☐ I am Not So Sure how I feel about my education, and NOT SURE if I want to change it.	☐ I am Not So Sure how I feel about being out of school, and NOT SURE if I want to change.
☐ I am Satisfied with my education, and DON'T WANT to change it now, but maybe in the future I would.	☐ I am Satisfied with being out of school, and DON'T WANT a change now, but maybe in the future I would.
☐ I am Very Satisfied with my education, and DEFINITELY DON'T WANT to change it.	☐ I am Very Satisfied with being out of school, and DEFINITELY DON'T WANT to change now.

I would accept a referral to Educational Services (Please Check One)
( ) In the next 3 months ( ) Not at all ( ) In the next 6 months ( ) I feel I can achieve my education goals on my own

**Adapted with the permission of Edward S. Casper, Ph.D, by the Maine Medical Center Department of Vocational Services*

Need For Change (NFC) 6.
Self-Rating Scale

Please share with us your opinion about your current employment situation

Name: _____ Age:_____ Circle: Male Female Other

Date: _____

Education Level: _____

Years Employed: _____ months: _____ Years Unemployed: _____ months: _____

If you are currently employed, respond to the questionnaire on the LEFT below. If you are currently unemployed, respond to the questionnaire on the RIGHT below.

Respond below if you are currently EMPLOYED First, read each of the 5 statements below. Then, consider which one best describes how you now feel about your job. Finish by placing an X in the box to the left of the statement that best describes how you now feel about your job.	**Respond below if you are currently UNEMPLOYED** First, read each of the 5 statements below. Then, consider which one best describes how you now feel about being unemployed. Finish by placing an X in the box to the left of the statement that best describes how you now feel about being unemployed.
☐ I am Very Dissatisfied with my job, and feel an URGENT NEED to change it.	☐ I am Very Dissatisfied with being unemployed, and feel an URGENT NEED to change.
☐ I am Dissatisfied with my job, and feel a STRONG NEED to change it.	☐ I am Dissatisfied with being unemployed, and feel a STRONG NEED to change.
☐ I am Not So Sure how I feel about my job, and NOT SURE if I want to change it.	☐ I am Not So Sure how I feel about being unemployed, and NOT SURE if I want to change.
☐ I am Satisfied with my job, and DON'T WANT to change it now, but maybe in the future I would.	☐ I am Satisfied with being unemployed, and DON'T WANT a change now, but maybe in the future I would.
☐ I am Very Satisfied with my job, and DEFINITELY DON'T WANT to change it.	☐ I am Very Satisfied with being unemployed, and DEFINITELY DON'T WANT to change now.

I would accept a referral to Employment Services (Please Check One)
( ) In the next 3 months ( ) Not at all ( ) In the next 6 months ( ) I feel I can obtain my own job
I would like to talk to staff about the impact of work on my benefits
( ) Yes ( ) No

**Adapted with the permission of Edward S. Casper, Ph.D, by the Maine Medical Center Department of Vocational Services*

Housing Needs Assessment

Date: _____ Name: _____ Birthday: _____ Gender: _____

Client # _____ Contact Phone Number: (___) _____ Other Contact: _____

PART 1

What is your current housing situation? _____

If housing is needed or a rental subsidy is indicated, proceed to Part 2.

PART 2-

For the following programs indicate the date discussed with the client, the date an application was made, and the result of the application.

PROGRAM	DATE ADVISED	DATE OF APPLICATION	RESULT
Shelter Plus Care			
Section 8			
BRAP			
Maine Housing			

I, the undersigned acknowledge that housing opportunities were discussed with me, and that I (please circle) DID / DID NOT apply for appropriate rental subsidies.

Name: _____ Date: _____

Signature: _____

Name of person administering questions: _____

Date _____

Signature: _____

ADULT LOCUS SCORING SHEET

Adult Level of Care Utilization System

Consumer Name: _____ **Assessment Date:** _____

Client ID Number: _____ **DOB:** _____

LOCUS Administration: ☐Baseline or Entry into Service ☐ Annual ☐Exit from Service

☐Other (Specify): _____

1. Calculation of LOCUS Composite Score						
Dimension	**Dimension Ratings (circle score)**					**Rating**
I. Risk of Harm	1	2	3	4	5	
II. Functional Status	1	2	3	4	5	
III. Medical, Addictive and Psychiatric Co-Morbidity	1	2	3	4	5	
IV. Recovery Environment						
A. Level of Stress	1	2	3	4	5	
B. Level of Support	1	2	3	4	5	
V. Treatment and Recovery History	1	2	3	4	5	
VI. Attitude and Engagement	1	2	3	4	5	
Composite LOCUS Score (*Add numbers in right column*)						
2. LOCUS - Derived Level of Care Recommendation: *(consult Determination Grid)*						

Notes:

- Bolded Dimension Ratings indicate Independent Criteria (IC). When IC is met, admission to the designated level is required regardless of the Composite Score.
- ***Risk of Harm**: Assign to **Level V** if scale score is 4; Assign to **Level VI** if scale score is 5).
- ***Functional Status and *Co-Occurring Conditions (Co-Morbidity):** Assign to **Level V** if scale score is a 4 and the sum of IVA (Level of Stress) and IVB (Level of Support) is greater than 2; Assign to **Level VI** if scale score is 5
- **Exception:** If the functional Status and/or the Co-Occurring Score is 4 and the sum of IVA and IVB is 2, the Composite Score determines level of care.

_____ _____

Rater Signature & Creditionals Date Rater ID Number

Diagnosis Sheet

Outside Source

Client Name:
Date of Birth:

Diagnosis	ICD 10 Code
Primary	
Secondary	
Tertiary	

Date Diagnosed/Reviewed on:		
Records attesting to diagnosis are in the client's chart:	☐ Yes	☐ No

Diagnosing Entity (hospital/office):
Provider/Case Manager Signature:
Printed Name & Credentials:

Fax to Wabanaki Case Management at: (207) 902-907-2048

Cornerstone Behavioral Healthcare **Wabanaki, Division of Cornerstone #10**

AC-OK Screen for Co-Occurring Disorders - Adults

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

Client Name:	**Client#**
DOB:	**Date of Service:**

In the past year: 1. Have you experienced serious depression (felt sadness, hopelessness, loss of interest, change of appetite or sleep pattern, difficulty going about your daily activities)?	☐yes ☐no
2. Have you experienced thoughts of harming yourself?	☐yes ☐no
3. Have you experienced a period of time when your thinking speeds up and you have trouble keeping up with your thoughts?	☐yes ☐no
4. Have you attempted suicide?	☐yes ☐no
5. Have you had periods of time where you felt that you could not trust family/friends?	☐yes ☐no
6. Have you been prescribed medication for any psychological or emotional problem?	☐yes ☐no
7. Have you experienced hallucinations (heard or seen things others do not hear/see)?	☐yes ☐no
	Number of 'yes' 1-7:
8. Have you been preoccupied with drinking alcohol and/or using other drugs?	☐yes ☐no
9. Have you experienced problems caused by drinking alcohol and/or using other drugs, and you kept using?	☐yes ☐no
10. Do you, at times, drink alcohol and/or use other drugs more than you intended?	☐yes ☐no
11. Have you needed to drink more alcohol and/or use more drugs to get the same effect you used to get with less?	☐yes ☐no
12. Do you, at any time, drink alcohol and/or use other drugs to alter the way you feel?	☐yes ☐no
13. Have you tried to stop drinking alcohol and/or using other drugs but couldn't?	☐yes ☐no
	Number of 'yes' 8-13:
14. Have you ever been hit, slapped, kicked, emotionally or sexually hurt or threatened by someone?	☐yes ☐no
15. Have you experienced a traumatic event and have since had repeated nightmares, dreams, and/or anxiety which interferes with you leading a normal life?	☐yes ☐no
	Number of 'yes' 14-15:
Client Signature:	
Provider Signature:	
Provider Printed Name & Credentials:	

Must be completed at intake and renewed yearly.

Cornerstone Behavioral Healthcare Wabanaki, Division of Cornerstone

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 ☐Natural Support/Other: • If no natural supports were involved, please explain:
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 ☐Family ☐Cultural/Gender ☐Recreational/Social	
☐ Peer Support	
☐ Transportation	
☐ Health Care ☐Dental ☐Eye Care	

Case Management ISP Signature Page

Client#

☐Hearing Health ☐Medical	
☐ 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):

SIGNATURES

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

Cornerstone Behavioral Healthcare Wabanaki, Division of Cornerstone

Crisis/Safety Plan

Client #:

Client Name:	
Date:	
Emergency Contact Name / Relationship *(update in Pimsy)*	**Telephone Number**

Describe what triggers a crisis for you:

Describe what a crisis feels like for you:

What is helpful (identify the strategies and techniques that may be utilized to stabilize the situation):

Who is helpful

Name	Relationship	Contact Number

Who/What is not helpful

Have you ever called a Crisis Program? ☐yes ☐no
Have you ever been in a crisis unit? ☐yes ☐No
Would you be interested in meeting with a crisis worker in your area to develop crisis plan? ☐yes ☐no
Do you have a crisis plan on file at your local crisis provider? ☐yes ☐no
Do you have a mental health advanced directive? (If so, please attach) ☐yes ☐no

STATEWIDE CRISIS: 1-888-568-1112 **LOCAL POLICE: 911** **LOCAL FIRE: 911**
STATE POLICE: 1-800-482-0730 **SUICIDE & CRISIS LIFELINE: 988** **WABANAKI CARELINE: 1-844-844-2622**
POISON CONTROL: 1-800-442-6350 **OTHER:**

Client Signature:	Date:
Parent/Guardian Signature:	Date:
Provider Signature:	Date:
Provider 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

Section 17 Eligibility Verification

Tenant Name: _____

Social Security Number: _____

Specific Section 17 Requirements: A member meets the specific eligibility requirements for covered services under Section 17 in the MaineCare Benefits Manual if:

A. The person is age eighteen (18) or older or is an emancipated minor;

AND

1. Has a primary diagnosis on Axis I or Axis II of the multiaxial assessment system of the current version of the *Diagnostic and Statistical Manual of Mental Disorders*, except that the following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:

   a. Delirium, dementia, amnestic, and other cognitive disorders;
   b. Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
   c. Substance abuse or dependence;
   d. Mental retardation;
   e. Adjustment disorders;
   f. V-codes; or
   g. Antisocial personality disorders;

AND

2. Has a LOCUS score, as determined by staff certified for LOCUS assessment by DHHS upon successful completion of prescribed LOCUS training, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2) and ACT (17.04-4), the member must have a LOCUS score of twenty (20) (Level IV) or greater.

OR

B. An AMHI Consent Decree Class Member is eligible to receive Community Integration Services (17.04-1) by virtue of class member status without meeting the eligibility requirements in 17.02-3(A).

I certify that the information contained on this form is true and complete to the best of my knowledge and belief.

_____

Clinician Signature and credentials Date

_____

Print Name and credentials Date

Wabanaki Public Health and Wellness
"The Wab" Peer Run Recovery Center
Annual Update

Name:_____ Date of birth:_____

Address:_____ Phone: (____)_____

_____

Emergency Contact:_____ Phone: (____)_____

Do you have any allergies? Yes( ) No ( ) Any medical conditions we should be aware of? Yes( ) No( )

If yes, please describe:_____

Our focus:

- Promote wellness and encourage healthy behaviors
- Provide a safe place for our community to go/"haven"
- Culturally congruent, offering Native American- teachings, spirituality, arts/crafts, etc
- Integrated with the community supports networks- to create and strengthen relationships
- Build awareness on various topics (ie: Wellbriety, nutrition, health)
- Available resources: phone, computer, pamphlets, community and tribal events
- A place to access intentional peer support
- A recovery oriented environment

Expectations for Participation:

- Participate drug and alcohol free
- Speak and behave in a kind, respectful, and appropriate manner
- Supervise and ensure safety of children at all times
- Be responsible for cleaning up after yourself
- Be relaxed in the room. No sleeping
- Keep speaker phones off. Keep phone conversations private
- Limit phone and computer use to 60 minutes when others are in the room
- Prevent the spread of germs and illnesses. Please stay home if sick
- Respect the privacy of others

I understand that Wabanaki Public Health and Wellness Peer Run Recovery Program will keep my information confidential.

By signing below, I am confirming that I have reviewed the description and expectations of participation.

Signature:_____ Date:_____

Witness:_____ Date:_____

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: D**rug/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.

A

❒**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: _____

Patient Identification

Name:

DOB:

Northern Light Health

E.

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

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

	Phone	Fax		Phone	Fax
Acadia Healthcare	(207) 973-6100	(207) 973-6822	Laboratory	(207) 973-6900	(207) 973-6999
Acadia Hospital	(207) 973-6100	(207) 973-6822	Lakewood	(207) 873-5125	(207) 861-9967
A.R. Gould Hospital	(207) 768-4175	(207) 768-4060	Maine Coast Hospital	(207) 664-5454	(207) 664-5398
Beacon Health	(207) 973-5692	(207) 989-1096	Mayo Hospital	(207) 564-4270	(207) 564-4360
Blue Hill Hospital	(207) 374-3458	(207) 374-3971	Medical Transport	(207) 275-2940	(207) 973-9487
C. A. Dean Hospital	(207) 695-5225	(207) 695-2254	Mercy Hospital	(207) 879-3373	(207) 822-2469
Eastern Maine Medical Center	(207) 973-7873	(207) 973-7867	Pharmacy	(207) 275-3216	(207) 561-4804
Home Care & Hospice	(800) 757-3326	(207) 400-8891	Sebasticook Valley Hospital	(207) 487-4026	(207) 487-3204
Inland Hospital	(207) 861-3150	(207) 861-3158			

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:
  - o Qualified sign language interpreters
  - o 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:
  - o Qualified interpreters
  - o 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.

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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 (رقم *1-888-986-6341*
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	
Street	City	State	Zip
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

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:_____

H.

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form).*

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:**
Wabanaki Case Management
Division of Cornerstone Behavioral Healthcare

***ADDRESS OF PERSON OR ORGANIZATION:**
PO Box 1356 Bangor ME 04402-1356
Phone: (207)992-0410 Fax: (207)907-2048

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date _____ to date _____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)

Cornerstone Behavioral Healthcare Wabanaki, Division of Cornerstone

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION **I.**

☐ 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: _____

M

AMHC AUTHORIZATION FOR RELEASING/OBTAINING INFORMATION

I agree to allow AMHC to: RELEASE TO: ☐ OBTAIN FROM: ☐ (CHECK THE APPROPRIATE BOX(es)

(Full name of person or organization authorized to receive/release information)

Address Phone (if available)

Relationship to Client

The specific information / material to be released is:

- ☐ Assessment & Evaluation Information
- ☐ Psycho-Social History
- ☐ Treatment Plan/Reviews
- ☐ Psychological Reports
- ☐ Psychiatric Evaluation
- ☐ Discharge Planning
- ☐ Crisis Plan
- ☐ Substance Abuse Information
- ☐ Medical History/Physical
- ☐ Medication Reports
- ☐ Progress Notes
- ☐ Vocational Information
- ☐ Academic Records
- ☐ Financial Information
- ☐ Disability Determination Report
- ☐ Other:

The information is to be used to:

- ☐ Verification of Services
- ☐ Service Coordination
- ☐ Legal Matters
- ☐ Discharge/Aftercare Planning
- ☐ Treatment/Service Planning
- ☐ Follow-up
- ☐ Laboratory/X-Ray Results
- ☐ Other:

This authorization for releasing/obtaining the above information is to be in effect through _____ unless otherwise revoked.
(not to exceed 6 months for children and 12 months for adults)

I understand that my health care provider(s) need my specific consent to disclose information related to any of the following. Such information may not be redisclosed by the recipient without my specific written consent.

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:

- Obtain a copy of this authorization, and to review and copy any information prior to it being released.
- Review my records and refuse authorization to disclose all or some of the information.
- 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. (See exception to this Right in the Notice of Privacy Practices in the Client Handbook given to you at intake).

☆ I understand that such refusal or revocation may result in improper diagnosis or treatment, denial of coverage or benefits or other insurance or other adverse consequences.

☆ I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure 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 _____ _____
Client Signature Date

_____ _____ _____
Signature of Authorized Person Basis for Authorization (Relationship to Client) Date

I hereby revoke this Authorization for the releasing/obtaining of information.

_____ _____
Client Signature Date

_____ _____ _____
Signature of Authorized Person Basis for Authorization (Relationship to Client) Date

CLIENT NAME: _____ **DATE OF BIRTH:** _____ **CLIENT #:** _____

Q.

CALAIS COMMUNITY HOSPITAL
24 Hospital Lane
Calais, ME 04619

Medical Record #: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Calais Community Hospital or _____ is hereby authorized
Name of Other Entity

to disclose my health information with: _____

Name of person/entity information is to be released to

_____

Address (Street, City, Zip) and Telephone Number (if known)

Patient's Name: _____ Date of Birth: _____ SSN: _____

I authorize the following information for the dates of _____ to be released:

___ Discharge Summary ___ Operative Report ___ History/Physical Exam ___ Pathology Report

___ Radiology Report ___ Radiology Films ___ Laboratory Report ___ Billing Information

Other: _____

This information is being release for the following purpose(s): ___ Continued medical care; ___ Marketing endeavors by the hospital (if marketing involves direct or indirect remuneration to the hospital from a third party); ___ Legal Purposes; ___ Personal Use; __ Other reason:_____

- ✓ I may revoke all or part of this authorization at any time by notifying the Health Information Management Department in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation. The revocation must be signed and dated.
- ✓ I may refuse to disclosure some of my health information.
- ✓ I understand the refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- ✓ I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. (42 CFR Part 2 prohibits unauthorized disclosure of substance use disorder records).
- ✓ I am entitled to a copy of this authorization and may inspect or copy the information to be disclosed.
- ✓ If I have any questions about this disclosure, I can contact the Health Information Department.
- ✓ I understand that I may be required to pay a reasonable fee for copying and retrieving these records.

I must specifically consent to release the following information. **CIRCLE** the appropriate word(s):

1. I **DO DO NOT** authorize disclosure of **substance use disorder records.**
2. I **DO DO NOT** authorize disclosure of **mental health information created by a mental health professional.**
3. I **DO DO NOT** wish to review such information prior to its release. This review must be supervised.
4. I **DO DO NOT** authorize disclosure of information regarding HIV infection status or any HIV test.

This authorization expires 90 days from the date signed.

_____ _____ _____
Witness Patient or Legal Representative (Identify Relationship) Date

Photo ID reviewed: _____ Copy provided to Requestor: _____

New: 10/02; Rev. RMO: 12/02, 07/07, 6/12, 3/13,12/14; 2/18 ami

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION T

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY Passamaquoddy Health/Indian Township Health	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

PSC Publishing Services (301) 443-6740 IF

FRONT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY Pleasant Point Health	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify) (CHS, Billing, etc.)* _____

☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

St. Croix Regional Family Health Center
136 Mill Street, Princeton, ME 04668
PH: 207-796-5503
FAX: 207-796-5528
www.scrfhc.org

RELEASE OF/REQUEST FOR INFORMATION - MEDICAL RECORDS

NAME: _____ D.O.B. _____

ADDRESS: _____

This information to be released to SCRFHC by:	*This information to be released by SCRFHC to:*
_____	_____
_____	_____
_____	_____

The purpose of this release is to

- ☐ Authorize both providers/facilities listed above to share information
- ☐ Release records for transfer of care of **medical** services
- ☐ Request records to be released to the person listed above
- ☐ To coordinate or provide clinical services

Information to be released from my medical record: *(Note: behavioral/mental health or substance related records require separate release)*

a. All Records _____
b. Only information related to: _____
c. Billing records: Time frame: ❑ Entire Record ❑ Records from _____(date) to _____ (date)

Please read the following statements indicating to the releaser to authorize or not authorize release/disclosure of sensitive information. Such information may not be re-disclosed by the recipient without my specific written consent.

Please check the appropriate box to authorize or not authorize the disclosure of the following information:

- I Do ❑ Do Not ❑ authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.
- I Do ❑ Do Not ❑ authorize disclosure of information referring to treatment or diagnosis of HIV, ARC, or AIDS.
- I Do ❑ Do Not ❑ want to review such information before it is released. I understand that any review must be supervised by designated staff.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature. I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility. I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws. I understand that I have a right to receive a copy of this authorization.

SIGNATURE OF PATIENT: _____ PHONE: _____

If signed by other than patient, indicate legal relationship: _____ DATE: _____

WITNESS: _____ DATE: _____

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RELEASE OF/REQUEST FOR INFORMATION - BEHAVIORAL HEALTH RECORDS

I, _____ (client, parent or legal guardian), authorize and give my consent for the release of confidential information about _____ (client).

This information to be released to SCRFHC by:

_____
_____
_____

This information to be released by SCRFHC to:

_____
_____
_____

The purpose of this release is to

- ☐ Authorize both providers/facilities listed above to share information
- ☐ Release records for transfer of care of **behavioral health** services
- ☐ Request records to be released to the person listed above
- ☐ To coordinate or provide clinical services

The specific information/material to be released is:

____ Treatment Plan/reviews	____ Psychological Reports	____ Clinical Summary	____ Diagnosis
____ Initial Assessment & Evaluation	____ Psycho-Social Assessment	____ Discharge Summary	____ Labs
____ Treatment Notes	____ Substance Abuse Info	____ Phone/verbal communication	

____ Other (specify): _____

I understand that no confidential information or material will be released without my specific written permission except where allowed by federal or state law, in circumstances such as emergency health or safety, imminent danger to self or others, or by court order. *(Please see the Rights of Recipients of Mental Health Services for further information).* I further understand that I may review all such information/material and may cancel or revoke this authorization in writing at any time, except to the extent that action has already been taken under this release. If this authorization has not been revoked, it will terminate one year from the date of my signature.

1. I Do ❑ Do Not ❑ authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse. The recipient may not disclose such information without my specific written consent.
2. I Do ❑ Do Not ❑ authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.
3. I Do ❑ Do Not ❑ authorize disclosure of information that refers to treatment or diagnosis of HIV infection, ARC, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.
4. I Do ❑ Do Not ❑ want to review such information before it is released. I understand that any review must be supervised by designated staff.

_____ _____ _____
Signature of Client/Legal Guardian/Parent Client Date of Birth Date

_____ _____
Witness Date

****

I am rescinding the above authorization as of _____ _____
Date **Signature**

Revised 06/08/2022