Cornerstone Behavioral Healthcare Acehelosu, a division of Cornerstone

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PRIMARY CARE PHYSICIAN

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