Caring and serving since 1883®

Community Health and Counseling Services

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(207) 922-4707
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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:

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

To **REQUEST** the following information:

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

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

Company: (if app.)_____

Attention [name]:_____

Address:_____

City/State/Zip:_____ Tel #:_____

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)*: _____

Original- CHCS Clinical Record - Copy, as needed, for release/request purposes. Copy for client (parent/guardian) as requested.

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): _____

Original- CHCS Clinical Record - Copy, as needed, for release/request purposes. Copy for client (parent/guardian) as requested.