TRI-COUNTY MENTAL HEALTH SERVICES

AUTHORIZATION FOR
RELEASE OF INFORMATION

Client Label

I hereby request and authorize Tri-County Mental Health Center and its employees and agents to use or disclose the individually identifiable health information as described below for:

Client Name: _____ Client DOB: _____ Client ID#:_____

I understand that this authorization is voluntary. I understand that if the organization/individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

❑ **Disclose information to** and/or ❑ **Obtain information from**:

_____Relationship to Client: _____

Name of organization/person/facility

_____

Address

Description of information: (*check only what applies*)

D	*O*		*D*	*O*	
❑	❑	Presence in treatment	❑	❑	Treatment/service plan
❑	❑	Diagnosis, brief description of progress	❑	❑	Discharge summary
❑	❑	Prognosis	❑	❑	Emergency services
❑	❑	Intake and assessment	❑	❑	Chemical dependency treatment
❑	❑	Other (specify)_____			

Purpose of requested disclosure: (*check only what applies*)

D	*O*		*D*	*O*	
❑	❑	Development of treatment/service plan	❑	❑	Ongoing treatment/care
❑	❑	Employment/government benefits	❑	❑	Coordination with family/friends
❑	❑	Coordination with treatment providers	❑	❑	Coordination with school
❑	❑	Other (specify)_____			

If the above named person has been diagnosed or treated for the following, I understand that I need to provide specific authorization to disclose related information. I may cross out any of the following which do not apply.

1. I (❑ **DO** ❑ **DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be disclosed by the recipient without my specific permission.
2. I (❑ **DO** ❑ **DO NOT**) authorize disclosure of information which refers to HIV test results, infection status.
3. I (❑ **DO** ❑ **DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of mental health.
4. I (❑ **DO** ❑ **DO NOT**) wish to review such information prior to its release. Review must be supervised.

I understand that the information indicated above is protected by law and cannot be released without permission, unless otherwise required by law. I further understand that I may review my records and refuse authorization to disclose all or some of the above health information, but refusal may result in improper diagnosis or treatment. I may receive a copy of my records.

I understand that this authorization will expire on the following date_____(not to exceed 1 year from date signed), or upon termination of services. I may revoke this authorization at any time upon my request to this agency, except where Tri-County already has acted upon a request for the release of my health information.

The agency will not receive payment for the use of the information disclosed.

I understand that I am entitled to a copy of this authorization form. Client received a copy ❑ Yes ❑ No

_____ _____ _____ _____

Signature of Client | Date | Witness Signature | Date

_____ _____ _____

Authorized Representative | Relationship | Date

Information requested should be sent to: Attn: _____

Tri-County Mental Health Services

_____

_____

*For this authorization to be valid, all spaces **must** be completed and the State and Federal citations must appear **On the Reverse Side***

For Persons/Organizations Receiving Substance Abuse Information:

This information has been disclosed to you from records protected by Federal confidentiality rules (*42 CFR Part 2*). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by *42 CFS Part 2*. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987)

For Persons/Organizations Receiving Mental Health Information:

This information has been disclosed to you from records protected by State confidentiality laws (*34-B M.R.S.A. Section 1207; Rights of Recipients of Mental Health Services*). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.