



STATE OF MAINE - DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)
CLIENT/PATIENT AUTHORIZATION TO RELEASE INFORMATION – DDPC & RPC

Dorothea Dix Psychiatric Center or Riverview Psychiatric Center
 HIPAA: Authorization for Release of Patient Information

Client/Patient's Name _____ DOB _____

I hereby authorize Dorothea Dix Psychiatric Center, P.O. Box 926, 656 Bangor Street, Bangor, ME, to
 Riverview Psychiatric Center, 250 Arsenal Street, 11 State House Station, Augusta, ME, to

(please note: hospital must be checked to ensure validity of release)

(Client/Patient may check either, or both, boxes)

..... Disclose Information **To...**

..... Obtain Information **From...**

This Person or Organization: _____
(insert name of person/organization to which information will be disclosed and/or from which information will be obtained)

Address *(must be complete)* _____

Fax #: *(required)* _____ Phone # to verify receipt of information: *(required)* _____

Relationship to Client/Patient *(guardian, any family member, friend, etc.)* _____

Information To Be Disclosed and/or Obtained

Please check **YES** or **NO** for each of the following:

- | | | | | | |
|---------|--------|---|---------|--------|--|
| Yes ___ | No ___ | Alcohol and/or Drug Treatment -
(Authorization is required to share ANY
information about alcohol/drug
treatment, whether spoken or written) | Yes ___ | No ___ | Locus Report |
| Yes ___ | No ___ | Any reference to or information
about alcohol or other drugs | Yes ___ | No ___ | Medical and/or Physical History |
| Yes ___ | No ___ | Assessments / Consultations | Yes ___ | No ___ | Outpatient Treatment |
| Yes ___ | No ___ | Treatment Plan/Crisis
Plans/Emergency Services | Yes ___ | No ___ | Physical Therapy (PT) and/or
Occupational Therapy (OT) |
| Yes ___ | No ___ | Discharge Summaries | Yes ___ | No ___ | Physician Orders, including Medical
Index |
| Yes ___ | No ___ | Face Sheet | Yes ___ | No ___ | Progress Notes |
| Yes ___ | No ___ | Goold Assessment(s) | Yes ___ | No ___ | Psychiatric History, Evaluations,
DSM |
| Yes ___ | No ___ | Lab/Radiation/EKG/Diagnostic
Reports | Yes ___ | No ___ | Psychological and/or Psychosocial
History, Reports, Evaluations |
| Yes ___ | No ___ | Legal / Financial | Yes ___ | No ___ | Social History (Recent and/or
Developmental) |
| Yes ___ | No ___ | Other _____ | | | |

Purpose(s) For Disclosing and/or Obtaining

- | | | | | | |
|---------|--------|---|---------|--------|---|
| Yes ___ | No ___ | Assistance to obtain government
benefits | Yes ___ | No ___ | Ongoing treatment/care
management plans |
| Yes ___ | No ___ | At the request of the Individual | Yes ___ | No ___ | Investigation of adult protective
complaints |
| Yes ___ | No ___ | Coordination with other treatment
provider | Yes ___ | No ___ | (Other) _____ |
| Yes ___ | No ___ | Coordination with
family/concerned persons | | | |
| Yes ___ | No ___ | Development of
Service/Treatment/Crisis Plans | | | |
| Yes ___ | No ___ | Eligibility determination
entitlements, insurance or
employment | | | |



STATE OF MAINE - DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)
CLIENT/PATIENT AUTHORIZATION TO RELEASE INFORMATION – DDPC & RPC

Dorothea Dix Psychiatric Center or Riverview Psychiatric Center

Please INITIAL and Circle Your Response to EACH of the following statements:

- I DO ____ / I DO NOT ____ authorize disclosure of information that refers to treatment or diagnosis of alcohol or drug abuse. I understand that it cannot be re-disclosed without my specific consent.
- I DO ____ / I DO NOT ____ authorize disclosure of information which refers to treatment or diagnosis of HIV or AIDS. I understand that some individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, insurance, or social/family relations.
- I DO ____ / I DO NOT ____ wish to review, prior to its release, any information I have authorized for release.

I understand that:

- the information I am releasing is protected by law
- it cannot be released without my written permission, unless otherwise specifically permitted by law.
- I have the right to review information and material to be released.
- I have the right to end this release at any time. To end it, I must do it in writing, and it must be delivered to my caseworker or his or her supervisor. I understand that I do not need to sign this form to receive services. I may get a copy of this release if I wish.
- the benefits, risks, and consequences of releasing or not releasing this information have been told to me.

Patient Signature or Mark

Date (required)

Guardian/Parent/Legal Representative Signature (specify role)

Date(required)

This authorization is valid until _____ (date not to exceed one [1] year)

To End this Release:

Signature/Mark Of Person Revoking Authorization

Relationship

Date(required)

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 CFR 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.

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. §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.

For Persons/Organizations Disclosing or Receiving HIV/AIDS related information

No person may disclose, or re-disclose, the results of an HIV test, without the specific informed consent and authorization by the person who is the subject of the test (as granted, or not granted, by the client in this client authorization form). Please read the law for more details and penalties. 5 MRSA §§19203, 19203-D, 19206