AUTHORIZATION

CLIENT NAME:_____

FOR RELEASING/OBTAINING DATE OF BIRTH:_____

Mental Health Information and/or Disability Related Information CLIENT #:_____

Dr. Tousignant intends to strongly protect any information, communication and records received in the course of treatment. Dr. Tousignant commits to helping you understand if release of your information may be helpful or cause unexpected outcomes, to the best of her ability, even though all possible outcomes are impossible to predict.

I,_____ agree to allow Dr. Kim Tousignant, [PO Box 1694, Bucksport, ME 04416; Phone: (207) 944-8881; FAX:(207) 469-1932]

to:

RELEASE TO: ☐ **OBTAIN FROM**: ☐ **Written** ☐ &/or **Electronic** (internet, email, text) ☐ &/or **Verbal** ☐

Name of Organization /Person_____

Street Address_____ Phone (if available)_____

City, Zip _____FAX(if available)_____

Website:_____Email:_____Other:_____

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 program admission, denial of insurance coverage or a claim for health benefits 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. Such information may not be redisclosed by Dr. Tousignant without my specific written consent.

The purpose of this release is to : _____

The extent and nature of information to be released or obtained includes:

☐ Clinical Intake/Diagnosis ☐ Progress Notes ☐ Final Discharge Summary
☐ Psychiatric Evaluation ☐ Treatment Plan/Plan of Care ☐ Other: _____

This authorization for releasing/obtaining information is to be **in effect through** _____(date) unless otherwise revoked.

_____I understand that **email & the internet** may not be secure forms of information transmission, as there are risks Dr. Tousignant cannot control; information may be read by a third party. I agree to accept those risks & allow Dr. Tousignant to send my information in electronic format if needed.

I understand that my health care provider(s) need my **specific consent** to disclose information related to any of the following. (please initial)

____**1.** **Substance/Alcohol/Drug Use &/or Abuse Treatment:** I **(☐ DO or ☐ DO NOT)** authorize disclosure of information which refers to any treatment or diagnosis of substance and or drug or alcohol use &/or abuse.

____**2.** **Mental Health Records:** I **(☐ DO or ☐ DO NOT)** authorize disclosure of information which refers to treatment or diagnosis of mental health by a provider or program

____**3.** **HIV Records:** I **(☐ DO or ☐ DO NOT)**authorize disclosure of information which refers to HIV test results, infection status, or treatment information. This information may have unexpected implications which could be positive or negative to you, and may result in discrimination if the data is misused.

____**4.** **Other Vocational-Medical:** I**(☐ DO or ☐ DO NOT)** authorize disclosure of information which refers to vocational – medical information.

____**5.** **Prior Review** : I **(☐ DO or ☐ DO NOT)**want to review such information before it is released. I understand that such reviews must be supervised.

I am signing this form voluntarily , and wish the information to be released in order to serve my best interest:

_____ _____

Client Signature **Date**

_____ _____ _____

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

_____ _____

Witness Date

REVOCATION: I hereby revoke this Authorization for the releasing/obtaining of information. I fully understand this does not apply to information that has already been released.

_____ _____

Client Signature Date

_____ _____ _____

Signature of Authorized Person Basis for Authorization (Relationship to Client Date (**REVISED 2/26/16)**