A yellow sunflowers on a blue and orange background

Description automatically generated

Blue Sky Counseling

70 First Rangeway, Waterville, ME 115 Franklin St. Bangor, ME

78 Madison Ave. Skowhegan, ME 04976

P: 207-616-0705 F: 207-241-4016

**Authorization to Release Confidential Information**

Client Name:(first, middle initial, last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City/State/Zip:

I hereby authorize Blue Sky Counseling, its authorized employees and agents to release my confidential information as outlined below: (check all that apply)

Give, Get and Discuss Records and information with:  Get Records and Information From:

Give Records and Information To:  Discuss Records and Information With:

Organization/Individual:

Relationship: Phone: Fax:

Address: City/State/Zip:

The specific records and information to be released include the following: **(Mark with an X only those items to be disclosed)**

**ALL INFORMATION BELOW**

Treatment Plan  Progress notes  Diagnoses  Psychological Testing  Discharge Summary

Medication List  Medical Info/Labs  Comprehensive Assessment  Crisis Intervention Assessment

Psychiatric Evaluation  Presence in treatment  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (be specific)

The records and information are to be provided or obtained for the purpose of: **(Place an X next to all appropriate responses)**

Ongoing Treatment  Educational  Financial  To Coordinate treatment efforts.

Aftercare Treatment  Legal  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Be Specific)

**\*\*I understand that my alcohol and/or drug treatment records are protected under Federal Regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in ONE YEAR or as otherwise specified.**

**If I have been diagnosed or treated for any of the following, I understand that my specific consent to disclose related information is necessary. (Must pick an option for each of the questions below.)**

1. **I DO  I DO NOT** Authorize information which refers to **treatment or diagnosis** of alcohol or drug abuse to be disclosed or obtained. Important: If checked “I DO,” then theclient **MUST** sign this consent, regardless of agefor the aboveinformation to be released. I understand my alcohol and substanceabuse record is protectedunder **Federal** **Regulation, 42 CFR Part 2**, which prohibits these records frombeing disclosed or re-disclosed **without** written consent, unless otherwise provided in a Regulation.While the Federal Regulation protects information from being re-disclosed, I understand that Blue Sky Counseling cannot guarantee that the recipient will not re-disclose this information to a third party.
2. **I DO  I DO NOT** authorize information concerning diagnosis and treatment of mental health conditions to be disclosed or obtained.
3. **I DO  I DO NOT** authorize information which refers to treatment or diagnosis of HIV Infection or AIDS to be disclosed or obtained.
4. **I DO  I DO NOT** want a copy of this consent.

I understand that:

* I have the right to review information prior to its being disclosed if I request to do so.
* I can refuse to disclose some or all the information in my treatment records, but if I do so, it could result in as improper diagnosis or treatment, or a denial of coverage or of a claim for health benefits, other insurance, or other adverse consequences.
* Blue Sky Counseling's provision of services does not depend on my giving this consent, except that my refusing consent connected with a research project may result in my not receiving treatment as a participant in that project.
* Any records and information disclosed to a recipient outside of Blue Sky Counseling may potentially be re- disclosed and no longer be protected by Federal or State law.
* I have the right to revoke this authorization at any time either verbally or in writing. Revocation will not cover information/material prior to the date but will prevent further disclosure. I understand that revocation may be the basis for denial of health benefits or other insurance coverage benefits.

This consent is effective until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(**Maximum is 1 YEAR for mental health/substance abuse services and 90 days for one-time disclosures).**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Guardian or Other Authorized Person's Signature