AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Christy A. Cole, LCPC, to use and/or disclose information in the form of written reports and/or verbal communication regarding:

Client Name	Date of Birth	Address

Telephone (home)	(work)	(Other)	Town, State	Zip Code

To: _____

_____

The Protected Health Information (PHI) that may be disclosed:

____ My complete health care record, including treatment notes, consultations, correspondence, amendments/corrections/clarifications of PHI, billing records, test results, etc.
____ Substance abuse treatment information.
____ Information regarding HIV/AIDS testing, diagnosis and treatment, etc.
____ Mental Health Treatment Information
____ Only information as specified: _____

For the purpose of:

____ Ongoing treatment or aftercare
____ To coordinate treatment efforts with family or concerned others
____ At the request of the individual
____ Other: _____

I understand that:

- Any information used and/or disclosed may be subject to redisclosure by the Recipient, and may no longer be protected by federal or state privacy regulations or laws. *I DO____/DO NOT_____ (check one)* authorize subsequent disclosures to be made of the identified PHI. This does not apply to redisclosure of alcohol or substance abuse treatment information that is protected under 42 CFR part 2.
- I may revoke all or part of this authorization, in writing, at any time by sending such notification to my therapist's office address, except to the extent that my therapist has already acted upon it.
- I am aware that I may refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in improper diagnosis and/or treatment, or other adverse consequence. I will not be denied treatment for failing to disclose information.
- This authorization is effective from today's date until _____.
- I understand that I have the right to receive a copy of this Authorization.

Note: Except as otherwise permitted under Maine law, this Authorization may not extend longer than 30 months.

Client Signature	Date	Witness Signature	Date

Signature of Legally Authorized Representative	Relationship to Client	Date

To the Recipient of Confidential Alcohol and Drug 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.