Maitre Care: Specialist Support Coordination

Consent to receive and release information

Date: _____

- ☐ I, the undersigned, **authorize** the release of, or request of information on my behalf to relevant authorities, care provider and person(s) to/ from Maitre Care and its entire entity for the purpose of achieving the best care possible.

Exceptions (if applicable): _____

- ☐ I, the undersigned **do not authorize** the release of, or request of information on my behalf to relevant authorities, care provider and person(s) to/ from Maitre Care and its entire entity for the purpose of achieving the best care possible.

I understand that my records are private and confidential and cannot be disclosed without my written consent, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected.

I understand that the specified information to be released may include but is not limited to history, diagnosis, treatment, illicit substance use, mental illness or any communicable disease.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the consent given.

This consent will expire in six (6 months) from the date of my signature, unless I revoke this prior that time via writing.

Participant or Legal Representative Full Name: _____

Address: _____

Signature:_____ Date: _____

Full Name of Witness: _____

Signature: _____ Date: _____