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Authorization to Release Confidential Health Information

Patient Name: _____DOB: _____

I, _____
(Patient/Parent/Guardian)

hereby authorize Henry C. Skinner, MD and Family Psychiatry of Maine, LLC to:
Yes [ ] No [ ] To **obtain** information from:
Yes [ ] No [ ] To **disclose** information to:
Yes [ ] No [ ] To **discuss** verbally with:

Name:_____Organization:_____

Address:_____

Phone:_____ Fax:_____

[ ] Any information or [ ] specific information_____
[ ] NOT certain information:_____

I DO [ ] DO NOT [ ] authorize disclosure of information about diagnosis or treatment of **substance abuse**
I DO [ ] DO NOT [ ] authorize release of any information about diagnosis/treatment for **HIV/AIDS.**
I DO [ ] DO NOT [ ] authorize release of any information about **mental health** treatment.
I DO [ ] DO NOT [ ] authorize exchange of this information **by fax.**

Unless earlier revoked, this consent **expires** on the following date: _____ (1 year or less). I understand that I may **revoke** this authorization at any time by giving written or verbal notice.

I understand that I may **refuse to release** some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse results. Dr. Skinner/Family Psychiatry of Maine will not release health information generated by other providers or facilities, unless specifically stated above. Statements added to records by clients and/or guardians will not be released without written consent. I understand that if the above listed information is disclosed, it is possible that it may be redisclosed by the recipient, or that it may no longer be subject to confidentiality protections. I understand I have a right to review material before it is disclosed.

I understand the matters discussed on this form. I release Henry C. Skinner, MD and Family Psychiatry of Maine LLC from any legal responsibility or liability for the disclosures of the above information to the extent indicated and authorized herein.

Client (14 and over):_____ Date: _____
OR: Parent/Guardian: _____ Date: _____
Relationship to Client: _____
Witness: _____ Date: _____