

**Amy Davenport Dakin, LCPC, LCMHC, NCC
PO Box 5360 Augusta, ME 04332
Phone (603) 257-0258**

CONSENT TO USE HEALTHCARE INFORMATION

Client:	ID#:	DOB:
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I understand that this office will make use of my health care information for purposes of my treatment, and other lawful functions performed by Ms. Davenport Dakin's private practice, including securing payment for services. I understand that this information may be available to persons who provide services to assist Ms. Davenport Dakin (billing) and will be subject to the same Federal Confidentiality Laws as she is.

I understand that this office holds/maintains information certain sensitive information related to my health care, such as:

1. Records covered by Federal rules that govern confidentiality of alcohol and drug abuse
2. Records covered by State rules governing mental health services
3. Records containing my, or other family member's mental health or medical diagnosis

My specific authorization is required to disclose such information to others. However, I consent that the use of such information by Ms. Davenport Dakin's practice, for the purposes of my assessment and treatment, and other lawful functions she is/may be required to address, including; a) securing payment for services b) other usual and customary health care operations. I understand that such information may be made available to other persons involved with this office (billing – clinical backup to notify client's and to protect records, in event Ms. Davenport Dakin has an emergency situation) . Person/s will be subject to the same Federal Laws of confidentiality as Ms. Davenport Dakin is.

I understand that I may refuse to allow the sharing of some, or all information, and that my refusal may result in an inaccurate or incomplete diagnosis, which has the potential to adversely impact my treatment process.

Client Signature	Date
Guardian Signature if appropriate	Date
Clinician: Amy Davenport Dakin, LCMHC, LCPC, NCC	Date

PLEASE SIGN HERE TO REVOKE THIS RELEASE

Client Signature	Date
Guardian /Representative Signature	Date
	Witness Signature & Date

