New Perceptions, Inc. P.O. Box 5360 Augusta, Maine 04332 207-941-0010 Fax (888)-977-1570	**Patient Name:** **Patient's Former Name or Alias:** **Patient Address:** **Date of Birth:** **Patient's Phone Number:**

Authorization to Disclose Health Information

By signing below I authorize New Perceptions, Inc. and its staff (*check applicable box(es)*):

To **DISCLOSE** my health information below **TO**: ***AND/OR*** To **OBTAIN** my health information below **FROM**:

Name of Person or Organization: _____
City/State/Zip Code: _____
Phone: _____ Fax: _____
By: Mail* Fax Email** (*specify recipient's email address*: _____)
Verbal Communication Other (*specify instructions*): _____

** Records provided by mail may be sent on a compact disc, unless you specify other instructions.*

Health Information to be Disclosed

□ My entire medical record (*complete "Sensitive Medical Information" section below if you wish sensitive types of health disclosed*)
□ My medical records for the following dates: _____/_____/_____ to _____/_____/_____
□ Only the following specific types of medical records or information for the following dates: _____/_____/_____ to _____/_____/_____
□ Clinical Records □ Immunization Records □ Lab Reports □ Hospital Records □ Radiology Reports □ Summary Records
□ Other Records (specify): _____

Unless I strike out this sentence, I intend this authorization to include disclosure of records and information the above disclosing person or organization has received from other healthcare providers, facilities or persons, unless such information may be withheld by law (see note below).

Sensitive Health Information

I specifically intend this authorization to include the disclosure of (*initial all that apply*):

[_____] **Mental and behavioral health records and information maintained by licensed mental health facilities, programs or agencies.** *I understand that I have the right to review any mental and behavioral health records maintained by licensed mental health facilities, programs or agencies at any reasonable time before deciding to authorize their disclosure on this form. Note, however, that licensed mental health facilities, programs or agency may refuse to disclose information or records they have obtained from another individual or facility through an assurance of confidentiality, though you have the right to receive a summary description of such information.*

[_____] **Records and information related to mental health services provided by licensed mental health professionals.**

[_____] **Substance use disorder program records and information (subject to protection under 42 C.F.R. Part 2).**

[_____] **HIV (Human Immunodeficiency Virus) information, including HIV test results, HIV status, and medical records containing HIV information.** *I understand that authorizing the disclosure of HIV records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.*

Authorization of Continuing Communications and Subsequent Disclosures

Unless I strike out any of the following, I intend this authorization to authorize continuing communications and subsequent disclosures of information within the scope of this authorization (i.e., the disclosing and recipient parties of my health care information are authorized to have continuing communications concerning the health care information authorized to be disclosed by this form, and to disclose information covered by this authorization that was created or related to clinical encounters occurring after the date of my signature below).

I authorize the disclosure of the above information for the following purpose(s) (check applicable box(es)):
□ At my request □ Treatment or Coordination of Medical Care □ Referral □ School Entry □ Transfer of medical care
□ Insurance coverage or payment purposes □ Legal Matter or Proceeding □ Disability
□ Other (specify): _____

	New Perceptions, Inc. Tel. (207) 941-0010 Fax (88)-977-1570	**Patient Name:** **Date of Birth:**

Duration or Expiration Date/Event: This authorization will expire twelve (12) months from the date of my signature below, unless earlier revoked by me or unless I enter an earlier expiration date or event here: _____.
To the extent that this authorization authorizes disclosure of mental health records and information maintained by a licensed mental health facility, program or agency, that part of the authorization will expire one (1) year from the date of my signature below, unless earlier revoked by me or unless I have entered an earlier expiration date or event in the space above.

By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of some or all the above healthcare information but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying New Perceptions in the manner described in New Perceptions' Notice of Privacy Practices (except to the extent that New Perceptions or any other person has already acted in reliance on it), but that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- New Perceptions will not condition services or treatment on whether I sign this authorization, unless authorized to do so by law.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I have the right to a copy of this signed authorization.

_____ _____
Date Signature of Patient or Patient's Authorized Representative***

_____
Printed Name

Authorized Representative's Legal Authority: □ Legal guardian □ Health care power of attorney agent
□ Health care surrogate □ Parent of a minor

*** Signature by an authorized representative certifies to New Perception that such person has the legal authority indicated to authorize disclosure of the patient's information and records on behalf of the patient.

FOR OFFICE USE ONLY

If the disclosure is by New Perceptions and the disclosure is partial or incomplete as compared to the patient's request, New Perceptions must notify the patient and recipient of the information that the disclosure is partial or incomplete by checking this box: □

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: 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 information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed 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 (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

Received by: _____ Location: _____ Date: _____