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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____, authorize _____ to: _____ (send)
_____ (receive) the following _____ (to) _____ (from):

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Information to be released:

- | | |
|---|---|
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological testing results |
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Service plans |
| <input type="checkbox"/> Progress reports | <input type="checkbox"/> Summary reports |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results |
| <input type="checkbox"/> Medical reports | <input type="checkbox"/> Entire record, except progress notes |
| <input type="checkbox"/> Personality profiles | <input type="checkbox"/> Psychotherapy notes |
| <input type="checkbox"/> Psychological reports | <input type="checkbox"/> Other, specify _____ |

The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review _____ Updating files
- Other (specify) _____

Sensitive information to be released:

I specifically authorize the release of my HIV/AIDS results and/or treatment, where applicable: Yes/No

I specifically authorize the release of psychiatric records, where applicable: Yes/No

I specifically authorize the release of alcohol and/or substance abuse treatment records: Yes/No

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider

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covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, it's purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: ___ Self ___ Parent/legal guardian ___ Legal representative ___ Other
(describe) _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date ___ / ___ / ___

Parent/guardians/personal representative (if applicable)

Signature: _____ Date ___ / ___ / ___

Witness Signature: _____ Date ___ / ___ / ___

**A photocopy of this authorization shall be considered as effective and valid as the original