Ocean Way Mental Health Agency

Authorization to Release Information

This authorization is only valid for the purpose stated below. Ocean Way Mental Health Agency (OWMHA) must obtain written authorization before requesting or disclosing any additional information from or to any other person or agency.

Client Name: _____ Date of Birth: _____S.S. #_____ MaineCare #:_____

Program/Address: Ocean Way Mental Health Agency, 78 Beechwood Street, Thomaston, ME 04861

Contact: _____ Office Phone #: 207-354-8184 Cell Phone #:_____

I hereby authorize Ocean Way Mental Health Agency:

[X] To Disclose to: and/or [X] To Obtain From:

Name of Person/Agency: _____

Address: _____

Email Address: _____ Cell Phone: _____

Phone Number: _____ Fax Number: _____

Authorized to leave message: [ ] Answering Machine [ ] With person in home [ ] Cell Phone

Information exchanged may be: [ ] Emailed/Faxed [ ] Written [ ] Verbal

Information to be Disclosed or Obtained (Client to initial ONLY what is needed):

- [ ] Referral Information
- [ ] Psychiatric Evaluation
- [ ] Medical Information
- [ ] Educational
- [ ] Emergency/Crisis Plan Information
- [ ] Social History
- [ ] OT/PT
- [ ] Any or All
- [ ] ISP/Treatment Plan
- [ ] Psychological Evaluation
- [ ] Speech/Language
- [ ] Other (heat & winterization)

Purpose of Disclosure:

[ ] Coordination with Family/Emergency Contact [ ] Coordination of Treatment/Services [ ] Other

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Please check Yes or No and **INITIAL** to the following provisions:

Yes [ ] No [ ] ____ I wish to review, prior to its release, any of the information I have authorized for release.

Yes [ ] No [ ] ____ I authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.

Yes [ ] No [ ] ____ I authorize disclosure of information that refers to treatment or diagnosis of alcohol or substance abuse issues. I understand that it cannot be re-disclosed without my specific information.

Yes [ ] No [ ] ____ I authorize disclosure of information that refers to treatment or diagnosis of HIV or AIDS.

This release will be valid from: _____ to: _____ (not to exceed one year.)

This release will automatically expire upon discharge; I understand my right to revoke this authorization at any time.

Revocation will not cover prior released material, but will prevent further release of information.

Date/Time Revoked: _____ Initials: _____

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise permitted by law. My signature below indicates that I have read this release and have had the benefits, risks, and consequences of releasing or not releasing information explained to me. I understand that I have a right to review all materials prior to their release to or from OWMHA and that the materials to be released will be reviewed with me upon my request. I understand that I do not need to sign this form to receive services and that I may review OWMHA's Notice of Privacy Practices before I sign this form.

Mental Health Information: This information has been disclosed from records protected by Maine Statute for confidentiality of mental health information (34-B M.R.S.A) This information should not be disclosed any further without the specific written consent of the person to whom it pertains, or otherwise permitted by law.

Substance Abuse Information: This information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). Federal regulations prohibit any further disclosure without the specific written consent of the person to whom it pertains, or otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Client/Guardian Signature: _____ Date: _____

OWMHA Staff's Printed Name/Signature/Title/Date: _____