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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: _____