Shalom House
HOME • HEALTH • HOPE

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Mary Haynes-Rodgers, LCSW
Executive Director

RELEASE/AUTHORIZATION TO USE/DISCLOSE CONFIDENTIAL INFORMATION

CLIENT NAME: _____ **CLIENT ID:** _____

REQUESTED BY: _____ **DATE OF BIRTH:** _____

I hereby authorize and request that Shalom House, Inc. release to or obtain from the agency named below the following information or records relating to my treatment.

RELEASE TO:
Person:_____
Agency/Relationship:_____

Please obtain the following information:
_ _ Discharge summary
_____ Psychiatric Evaluation/Assessments
_ _ Treatment Plans (RSP/ISP) and reviews
_ _ Psychosocial history
_ _ Ongoing treatment information
_ _ Housing information
_ _ Other:_____

The purpose of this release is:

_____
_____

OBTAIN FROM:
Person:_____
Agency/Relationship:_____

Please obtain the following information:
_ _ Discharge summary
_____ Psychiatric Evaluation/Assessments
_ _ Treatment Plans (RSP/ISP) and reviews
_ _ Psychosocial history
_ _ Ongoing treatment information
_____ Housing information
_ _ Other:_____

The purpose of this release is:

_____
_____

Must be initialed by client:
____**I DO** ____ **DO NOT** want any information released by Shalom House that may be covered by federal rules relating to confidentiality of alcohol or drug abuse treatment released.
____**I DO** ____ **DO NOT** want any information released by Shalom House that may relate to my diagnosis or treatment for HIV infection released.
This information is protected by Federal Confidentiality rules (42 C.F.R. Part 2)

- **Right to Refuse:** I understand that I may refuse authorization to disclose some or all of the information in my treatment record, but that such a refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or insurance, or other adverse consequences.
- **Right to Revoke:** I understand that I have the right to revoke this authorization at any time, provided that I do so in writing or verbally.
- **Right to Review:** I understand that I have the right to inspect or copy any information to be used and/or disclosed under this authorization.
- I understand that the above information may be covered by the rules of the Maine Department of Health and Human Services (the "Rights of Recipients of Mental Health Services"). I waive my right to review this information prior to its disclosure.

THIS RELEASE/AUTHORIZATION WILL EXPIRE ON _____ **(DATE, TIME, EVENT)**
This Authorization shall be in force and effect until the expiration date noted above, at which time this authorization to use or disclose my protected health information expires.

I choose to willingly release the information stated above. I understand the information will be used only for the purposes indicated and cannot be released to anyone else without my written consent unless otherwise provided for in legislation regarding protected health information and confidentiality of mental health records.

CLIENT SIGNATURE:_____ **DATE**:_____
(or Guardian)

WITNESS: _____ **DATE:** _____