

AUTHORIZATION TO RELEASE & OBTAIN INFORMATION

Name of Client (Print legibly):	DOB://	
The authorized signers give permission for The Opportunity Alliance	to:	
RELEASE OBTAIN VERBALLY DISCUSS	the identified information with:	
Name: Organization OR Specific Person & Title	/	
	,	
Address: Phone:(207) Fax: (207)		
Information to be RELEASED (Check only those that apply) ☐ Presence in Treatment Only ☐ Progress in Program	Information to be OBTAINED (Check only those that apply) Presence in Treatment Only Progress in Program	
Assessment Service Plan Discharge/Aftercare Plan	Assessment Service Plan Discharge/Aftercare Plan	
☐ Diagnostic Summary ☐ Psychiatric Evaluation ☐ Financial Info	☐ Diagnostic Summary ☐ Psychiatric Evaluation ☐ Financial Info	
☐ Medical Info ☐ Lab Results ☐ Educational Records	Medical Info Lab Results Educational Records	
☐ Transportation ☐ Employment ☐ Housing ☐ Child Care	☐ Transportation ☐ Employment ☐ Housing ☐ Child Care	
Other (be specific):	Other (be specific):	
Date range of records needed:/ to/_	J	
	nning Educational Legal Financial /Insurance	
I DO I DO NOT authorize disclosure of information of DRUG or ALCOHOL ABUSE TREATMENT OR DIAGNOSIS. [CANNOT be re-disclosed without further authorization]	I DO I DO NOT authorize disclosure of information on treatment or diagnosis of HIV / AIDS	
This release will expire on:// No longer than month day year	: <u>1 year</u>	
My signature indicates that: [review reverse side] > I consent freely, voluntarily and without coercion, and have > The risk, benefits and consequences of releasing or not rele > I authorize releasing/obtaining information as specified abortion and disclose it to others without my further consent, use > The advisories on the reverse side of this form have been expected by I understand that I can revoke this authorization at any time.	easing this information have been explained to me. ove and understand that those who receive this information unless permitted by law. explained to me and I understand them.	
I DO I DO NOT wish to review the above identif	ied records prior to release Date	
Client Print Name: Client Signature:		
Parent/Guardian Signature:		
Staff/Witness Print Name:		
Staff/Witness Signature and Credentials:		

Revision date: 2/20/2020

RETRACTION OF RELEASE OF INFORMATION

- I am retracting further use of this authorization for release of information effective as of this date.
- This revocation is subject to any disclosure prior to receiving the revocation.
- I understand that revocation may be the basis for denial of health or other insurance coverage benefits.

Client Signature:	Date:
Verbal Retraction	Date:
TOA Staff receiving verbal retraction / Credentials / Program	

ADVISORIES

- ✓ You may refuse to sign the authorization, or to disclose some or all of your financial, tenant, and/or health care information, however, your refusal may result in improper service, diagnosis or treatment; denial of coverage or a claim for health benefits, denial of assistance, insurance coverage or benefits; or other adverse consequences.
- ✓ You may revoke this authorization at any time by a written or verbal revocation to staff of this organization.

 However, this revocation is subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation.
- ✓ You are entitled to a copy of this authorization form.

FOR PERSONS / ORGANIZATIONS RECEIVING SUBSTANCE ABUSE INFORMATION

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 this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(52 FR 21809, June 9, 1987; 52 FR 41997, November 2, 1987)

FOR PERSONS / ORGANIZATIONS RECEIVING MENTAL HEALTH INFORMATION

This information has been disclosed to you from records protected by HIPAA and Maine confidentiality laws (34-B M.R.S.A. Section 1207); *Maine Rights of Recipients of Mental Health Services* – 34-B M.R.S.A. Sections 3003, 1500(4 & 7) and may include information protected by federal confidentiality rules identified above (Confidentiality of Alcohol & Drug Abuse Client Records). This information remains confidential and should not be disclosed any further, except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

To Contact: Director of Licensing and Compliance

The Opportunity Alliance 50 Lydia Lane South Portland, ME 04106 (207) 874-1175

Toll free: 1-(877) 429-6884

Fax: (207) 200-2605

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