Child & Adolescent
Psychiatric Services of Maine
Peter Y. Kang, DO
Board Certified Child and Adolescent Psychiatrist

AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION

Patient Name: _____ DOB: _____

I understand that health care information is confidential and will not be released without my authorization unless permitted by law. I understand that I have a right to refuse authorization to disclose all or some of the health care information, but refusal may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences. The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the authorization.

I hereby authorize Child & Adolescent Psychiatric Services of Maine to: ☐ **OBTAIN** ☐ **RELEASE** ☐ **EXCHANGE**

Name of Individual or organization: _____

Address: _____

Phone: _____ Fax: _____

By law, providers are required to release the minimum amount of information necessary to carry out the purpose of a release. Please indicate below exactly which records you would like released:

☐ Verbal Communication ☐ Medication History ☐ Initial Evaluation ☐ Lab Results ☐ Office Visits

☐ Treatment Plans ☐ Psychological Testing ☐ Other (please specify): _____

The information and material above may only be used for the following purpose(s) please check below:

☐ Coordination of Care ☐ Obtain Records ☐ Determination of Services ☐ Legal Matter(s)

☐ Other (please specify): _____

By checking the boxes below, I authorize that specific health information to be released:

□ I Do □ I Do Not Authorize the disclosure of information, which refers to treatment and/or diagnosis of drug or alcohol abuse (federal drug & alcohol regulations, 42 CFR 2.31). Such information may not be disclosed by the recipient without my specific written consent.

□ I Do □ I Do Not Authorize the release of any information that may relate to diagnosis/treatment for HIV, ARC, AIDS.

□ I Do □ I Do Not Authorize the release of any information that may relate to my Mental Health Treatment.

□ I Do □ I Do Not - Want to review the Mental Health Information prior to it being sent.

This authorization expires in **twelve (12) months** from the date hereof. I have the right to revoke this authorization in writing at any time. Revocation will not cover information/material released prior to that date, but will prevent further release of information. I understand that revocation may be the basis for denial of health benefits or other insurance coverage, or both.

My signature below indicated that I have read this release form and have had all of my questions answered, if any.

- I consent to the release of information as recorded on this form, and that I understand what this form authorizes.
- I authorized the party(ies) listed in section 1 of this form to make subsequent disclosures to the same recipient pursuant to this authorization.
- I understand that information released might be further released by the receiving party and that is this occurs, ***Child & Adolescent Psychiatric Services of Maine*** cannot guarantee the protection of this information once disclosed.
- I understand that I have a right to require a copy of the authorization.

X_____ _____

Patient and/or Guardian's Signature Date

☐ Parent ☐ Legal Guardian ☐ Other Legally Authorized Representative: _____