Rivers Edge Behavioral Health Services, LLC
at Bella's House
PO Box 27; 883 Main Street, Springfield, ME 04487
(P) 207-738-2488 (F) 207-738-3815

Name:_______________________________ Date of Birth:__________________________

Authorization to Release □ Receive □ Information or Both □

I understand that my alcohol and or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1966 (HIPAA), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. These rules prohibit the recipient of confidential information from further disclosure of it, unless that disclosure is expressly permitted by your written consent or as otherwise permitted by 42 C.F.R. Part 2. I understand that generally Rivers Edge Behavioral Health Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances, I may be denied treatment if I do not sign a consent form. I understand that I may request a list of records disclosed to whom, when, and for what purpose at any time during or after the Treatment. I will be given a copy of this form if I request it.

I, ______________________________________authorize Rivers Edge Behavioral Health Services and

____

____

(Name, agency, address, phone)

to communicate with and/or disclose to one another the following information:

□ All my substance use records

Or only the following types of records:

□ Admission status □ Biopsychosocial History □ Medical Consultation

□ Presence in Treatment □ Treatment Plan □ Discharge Summary

□ Admission Summary □ Progress in Treatment □ Psychological/Psychiatric Eval

□ Other:

____

The purpose of this disclosure is to:

□ Schedule appointments □ Plan or coordinate treatment and services

□ Facilitate meeting legal obligations □ Obtain/maintain employment, government, other benefits

□ Client request

□ Other: ____

I □ do □ do not authorize information to be faxed/emailed. I understand that there are confidentiality risks in fax/email transmissions.

I □ do □ do not authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse.

I □ do □ do not authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.

I □ do □ do not authorize disclosure of information that refers to treatment or diagnosis of HIV, ARC or AIDS.

I □ do □ do not wish to review my Rivers Edge Behavioral Health Services records before their release. If I do, a program director or designee will supervise my review and document the supervision below.

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken on it. Unless revoked, this consent will expire automatically:

□ in one year from the date of signature OR

□ Upon a specific date, event, or condition as listed here:____

(Specific date, event, or condition)

Client Signature: ____ Date: ______________________

Witness Signature: ____ Date: ______________________

If the individual is unable to sign due to legal incapacity, the signature of the individual's personal representative is required. Documentation of the personal representative's legal authority must be attached.

Signature of Personal Representative: ____

Print:____Date: _____________________

Legal Authority: ____

REVOCATION:

□ in writing □ by phone □ in person □other: _____________Date:_____________

Date revocation received by phone or in writing: ___________________________________

Staff Signature: ____

By signing below, I am revoking this Consent for the Release of Confidential Health Information.

Client Revocation: ____Date: ____________________

Office:

The records were reviewed with me as required above:

Client Signature: _________________________________Date of Review: ___________________

Staff Signature: _________________________________ Date of Review: ____________________