Pediatric Associates
of Lewiston

BEHAVIORAL HEALTH RELEASE FORM

This authorization is for the use or disclosure of protected behavioral health information pertaining to:

Patient Name: _____

Address:_____

DOB : _____ Phone: _____

I hereby authorize the following health care provider:

Name: _____

Address: _____

To *release* my protected health information to:

Name: _____

Address: _____

Purpose of disclosure:

- ☐ Behavioral Healthcare _____

Other_____

Protected health information to be released:

General Medical Records

- ☐ Psychiatric and Social Service Patient Records
- ☐ Neurology Records

Time frame: ☐ entire record ☐ records from (date) to (date)

Your specific permission is required to disclose information regarding the following:

***(check box and sign your name to specify protected health information to be disclosed*)**

- ☐ Treatment by Mental Health Professional or Program _____
- ☐ Drug/Alcohol Abuse _____
- ☐ HIV Test Results or Status _____

(Maine law requires our practice to inform you that disclosing your HIV infection status may have consequences, such as negative treatment in your personal life, at work or by insurance companies, if this information is misused. It can be important for providing you needed services & healthcare.)

- Continued -

My Rights:

- I understand that I am not required to sign this form and **Pediatric Associates of Lewiston** will not condition treatment, payment of services, or eligibility for services on whether I sign this form. I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences.

- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.

- I understand that I have the right to access or copy the PHI described in this form by making a written request to the **Privacy Officer** of this practice: **Jenny Giles/ 33 Mollison Way, Lewiston ME 04240 207-784-5782**. A copying fee may be charged as permitted by law. I have a right to review mental health records prior to the release of those records, within 3 working days of my request.

- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at **Pediatric Associates of Lewiston**. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

- I understand the PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.

- I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.

- I understand that I have a right to receive a copy of this authorization.

Expiration: This authorization becomes effective immediately and shall expire on: _____.
If no date is given, this authorization is valid for **one year** from signature date.

Signed: _____ **Date:** _____

Print name: _____

Relationship to Patient: _____

Witness Signature: _____

Rev. January 2013