Client Name:­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby allow Lifeline for ME, LLC, located at 76 Main St., Livermore Falls ME, 04254, (phone: 207.320.3305, fax: 207.645.2372) and its approved staff or agents to release/share my Protected Health Information as outlined below. (Check approved items below)

[ ]  Receive, disclose, and discuss information with: [ ]  Disclose records and information to:

[ ]  Receive records and information from: [ ]  Discuss records and information with:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Role/Rel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_

(A) The period for which information is requested is: From \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ To \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

(B) The specific information to be released is: [ ]  **All Information Below** or:

 Only the following information noted: [ ]  Lab reports [ ]  Medical Hx/physical

 [ ]  Discharge summary [ ]  Psychiatric evaluation(s) [ ]  Progress notes

[ ]  Diagnosis [ ]  Psychological assessment(s)/testing [ ]  Treatment history

[ ]  Initial evaluation/intake assessment [ ]  Medications [ ]  Treatment plan(s)

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(C) The reason for the release of this information is:

[ ]  Assist with evaluation/assessment [ ]  Treatment planning [ ]  Judicial proceedings

 [ ]  Coordination of services [ ]  Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(D) If I have been diagnosed or treated for any of the following, I understand that my specific consent to disclose related information is necessary. In no event may any such information, if applicable, be disclosed without my specific consent.

1. I ([ ]  DO / [ ]  DO NOT) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific written consent.
2. I ([ ]  DO / [ ]  DO NOT) authorize disclosure of information which refers to mental health/psychiatric treatment or diagnosis.
3. I ([ ]  DO / [ ]  DO NOT) authorize disclosure of information which refers to treatment or diagnosis of HIV, ARC, or AIDS.

(E) I ([ ]  DO / [ ]  DO NOT) wish to look at the information before it is released. This review must be documented.

(F) I ([ ]  DO / [ ]  DO NOT) agree to the future release of information to the above person/organization during the approved time period.

(G)This agreement to release information has an **Expiration Date of**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_. This date can be no longer than (12) months.

I understand that:

* I can cross out any checked off item I do not agree with and I can revoke this approval at any time by completing the reverse side of this authorization. I can refuse to release some or all of my records. However, such refusals may result in improper diagnosis, improper treatment, and denial of insurance coverage or have other adverse consequences. The provider will not condition treatment on signing this authorization, unless the health care is solely for the purpose of creating the information for the person listed above.
* Lifeline for ME, LLC cannot control people or organizations receiving this information to prevent re-release of it without my approval. Lifeline for ME, LLC will not release information created by other practitioners or facilities.
* I understand the matters discussed on this form. I release the provider, its employees, officers, and business associates from any legal responsibility or liability for the disclosures of the above information to the extent indicated and authorized herein.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

RELATIONSHIP (if other than client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

#### REVOCATION

I understand it is my right to revoke this authorization at any time. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits. I have been informed of the potential consequences resulting from my revocation of this authorization I further understand that revoking this release will not affect the information already released as a result of my original approval to do so but understand that all future releases of this information will not be allowed after the date below.

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

RELATIONSHIP (if other than client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_