www.anglezbhs.com 1-844-294-5306 fax

AngleZ Behavioral Health Services, PA

AUTHORIZATION TO RELEASE INFORMATION

This authorization is only valid for the purpose stated below. AngleZ Behavioral Health Services, PA must obtain written authorization before requesting or disclosing any information from or to any other person or agency.

Client Name: ____Client ID#: ___________DOB:___________

I authorize AngleZ Behavioral Health Services, PA Phone/Fax: 1-844-294-5306
841 Riverside Drive Augusta, ME 04330

☐ **TO DISCLOSE TO:**
☐ **TO OBTAIN FROM:**

Information exchanged may be: Written ☐ Verbal ☐ Faxed ☐
(Include fax number and phone number to verify receipt only if fax is being used to disclose/obtain information)

Name of Organization:____

Contact Person/Relationship (If applicable):____

Address, City, State, Zip:____

Phone:________________________ Fax:_________________________

Information to be disclosed or obtained: Client must **INITIAL** all information to be obtained or disclosed that applies to monitor, assess and coordinate services identified in your treatment plan with the above noted provider

________ Assessment Information ________ ISP/Treatment Plan ________ Discharge Summaries

________ Relevant Financial Info ________ Psych-Social History ________ Psychiatric Report Diagnosis
________ Medical History/Physical Report ________ Crisis Plan ________ Psychological/psychosocial Reports
________ Ongoing Communication for Treatment & Discharge Planning ________ Educational Reports
________ Alcohol/Drug Treatment (Authorization is needed to share any information alcohol/drug treatment, spoken/written)
________ Other:
________I Do ____________I **Do Not** Authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness
________ I Do ____________I **Do Not** Authorize disclosure of information which refers to treatment or diagnosis of drug/alcohol abuse. I understand that it cannot be re-disclosed without my specific consent.
________I Do ____________I **Do Not** Authorize disclosure of information which refers to treatment or diagnosis of HIV, ARC or AIDS. I understand that some individuals about whom such disclosures have been made have encountered discrimination from others in the area of employment, housing, insurance, or social/family relations.
________ I Do ____________I **Do Not** Wish to review, prior to its release, any information I have authorized for release. Information sent has been reviewed on: ____________________ Client/Guardian Initials: __________

This release expires on ____________________________Not to exceed one (1) year). This release will automatically expire upon discharge. I understand my right to revoke this authorization at any time. Revocation will not cover prior released material, but will prevent further release of information.

Date/Time Revoked________________ Initials _____________

I understand that the information indicated is protected and cannot be released without my written permission, unless otherwise permitted by law. My signature below indicates that I have read this release and have had the benefits, risks, and consequences of releasing or not releasing information explained to me. I understand that I have a right to review all materials prior to their release to or from ABHS and that the materials to be released will be reviewed with me upon my request. I understand that I do not need to sign this form to receive services and that I may review ABHS Notice of Privacy Practices before I sign this form.

Client/Guardian Signature:_______________________________________ Date:_____________

AngleZ Staff Signature/Title:____ Date:________________

Mental Health Information: This information has been disclosed from records protected by Maine Statute for confidentiality of mental health information (34-B M.R.S.A.) This information may not be re-disclosed any further without the specific written consent of the person to whom it pertains, or otherwise permitted by law. **Substance Abuse Information:** This information has been disclosed from records protected by Federal confidentiality regulations (42 C.F.R. Part 2). Federal regulations prohibit any further disclosure without the specific written consent of the person to whom it pertain, or otherwise permitted by such regulations. A general authorization for release of medical or other information is NOT sufficient for this purpose. The federal regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.