The Opportunity Alliance

AUTHORIZATION TO RELEASE & OBTAIN INFORMATION

Name of Client (*Print legibly*)**:** _____ **DOB:** ___/___/_____

The authorized signers give permission for The Opportunity Alliance to:

☐ **RELEASE** ☐ **OBTAIN** ☐ **VERBALLY DISCUSS** the identified information with:

Name: _____ / _____

Organization OR Specific Person & Title *Relationship to client*

Address: _____ Phone: (207) _____

Fax: (207) _____

Information to be RELEASED (*Check only those that apply*)

☐ Presence in Treatment Only ☐ Progress in Program

☐ Assessment ☐ Service Plan ☐ Discharge/Aftercare Plan

☐ Diagnostic Summary ☐ Psychiatric Evaluation ☐ Financial Info

☐ Medical Info ☐ Lab Results ☐ Educational Records

☐ Transportation ☐ Employment ☐ Housing ☐ Child Care

☐ Other (*be specific*):

Information to be OBTAINED (*Check only those that apply*)

☐ Presence in Treatment Only ☐ Progress in Program

☐ Assessment ☐ Service Plan ☐ Discharge/Aftercare Plan

☐ Diagnostic Summary ☐ Psychiatric Evaluation ☐ Financial Info

☐ Medical Info ☐ Lab Results ☐ Educational Records

☐ Transportation ☐ Employment ☐ Housing ☐ Child Care

☐ Other (*be specific*):

Date range of records needed: ___/___/___ to ___/___/___

PURPOSE OF DISCLOSURE: ☐ To Coordinate Treatment/Service ☐ Aftercare Planning ☐ Educational ☐ Legal ☐ Financial /Insurance ☐ General Assistance Application ☐ Verbal/Email Correspondence ☐ Other (*be specific*):

☐ I DO ☐ I DO NOT **authorize disclosure of information on DRUG OR ALCOHOL USE TREATMENT OR DIAGNOSIS. [CANNOT be re-disclosed without further authorization]**

☐ I DO ☐ I DO NOT **authorize disclosure of information on treatment or diagnosis of HIV / AIDS**

This release will expire on: ___/___/___ ***No longer than: 1 year***

month day year

My signature indicates that: *[review reverse side]*

- I consent freely, voluntarily and without coercion, and have been provided the opportunity to ask questions.
- The risk, benefits and consequences of releasing or not releasing this information have been explained to me.
- I authorize releasing/obtaining information as specified above and understand that **those who receive this information cannot disclose it to others without my further consent, unless permitted by law**.
- The advisories on the reverse side of this form have been explained to me and I understand them.
- I understand that I can revoke this authorization at any time.

☐ **I DO** ☐ **I DO NOT wish to review the above identified records prior to release**

Date

Client Print Name: _____ _____

Client Signature: _____ _____

Parent/Guardian Signature: _____ _____

Staff/Witness Print Name: _____ _____

Staff/Witness Signature and Credentials: _____ _____

Revision date: 9/26/2023

RETRACTION OF RELEASE OF INFORMATION

- I am retracting further use of this authorization for release of information effective as of this date.
- This revocation is subject to any disclosure prior to receiving the revocation.
- I understand that revocation may be the basis for denial of health or other insurance coverage benefits.

Client Signature: _____ Date:_____

Verbal Retraction: _____ Date:_____

TOA *Staff receiving verbal retraction / Credentials / Program*

ADVISORIES

- ✓ You may refuse to sign the authorization, or to disclose some or all of your financial, tenant, and/or health care information, however, your refusal may result in improper service, diagnosis or treatment; denial of coverage or a claim for health benefits, denial of assistance, insurance coverage or benefits; or other adverse consequences.
- ✓ You may revoke this authorization at any time by a written or verbal revocation to staff of this organization. However, this revocation is subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation.
- ✓ You are entitled to a copy of this authorization form.

FOR PERSONS / ORGANIZATIONS RECEIVING SUBSTANCE USE INFORMATION

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any patients receiving substance use services.

FOR PERSONS / ORGANIZATIONS RECEIVING MENTAL HEALTH INFORMATION

This information has been disclosed to you from records protected by HIPAA and Maine confidentiality laws (34-B M.R.S.A. Section 1207); *Maine Rights of Recipients of Mental Health Services* – 34-B M.R.S.A. Sections 3003, 1500 (4 & 7) and may include information protected by federal confidentiality rules identified above (Confidentiality of Alcohol & Drug Use Client Records, 42 CFR Part 2). This information remains confidential and should not be disclosed any further, except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

To Contact:
Continuous Quality Improvement

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