

Millinocket School Department

P.O. Box 30
Millinocket, Maine 04462
(207) 746-3500

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize personnel in the Millinocket School Department:
Client/guardian

Form with two columns: 'To RECEIVE the following information:' and 'To DISCLOSE the following information:'. Each column contains a list of checkboxes for various types of information to be shared.

Information to be RECEIVED FROM/DISCLOSED TO:

Company/Agency: \_\_\_\_\_ Name: \_\_\_\_\_
Address: \_\_\_\_\_

The purpose of this release is:

- Checkboxes for: Coordination of services, Obtain records, Determine eligibility for services, Legal purposes, ISP/IEP planning, Other (please specify)

I DO [ ] DO NOT [ ] authorize release of any information that may be covered by federal rules relating to the confidentiality of alcohol or drug abuse treatment.
I DO [ ] DO NOT [ ] authorize release of any information that may relate to diagnosis/treatment for HIV, ARC, or AIDS.
I DO [ ] DO NOT [ ] authorize release of any information that may relate to mental health treatment.

Unless earlier revoked, this authorization will remain in effect until \_\_\_\_\_ (maximum 1 year). I authorize the above-named provider to make subsequent disclosures to the same recipient pursuant to this authorization.

I understand that the above information may be covered by the rules of the Maine Department of Behavioral and Developmental Services (the "Rights of Recipients of Mental Health Services" or the "Rights of Recipients of Mental Health Services Who Are Children In Need of Treatment").

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse consequences. The provider will not deny treatment on signing this authorization, unless the health care is solely for purpose of creating the information listed above for the person listed above.

Per district standards, the Millinocket School Department will NOT release information created by other practitioners or facilities. Statements added to records by students and/or guardians will not be released without written consent. I understand that if the above

listed information is disclosed, it is possible that it may be redisclosed by the recipient, or that it may no longer be subject to confidentiality protections.

Student Name: \_\_\_\_\_

I waive my right to review this information prior to its disclosure:  Yes  No

I authorize the provider to send/receive these records by fax:  Yes  No FAX# \_\_\_\_\_

I acknowledge that I have been offered a copy of this authorization:  Yes  No

I understand that I may cross out any words on this form with which I disagree, and that I may revoke this authorization at any time.

**Signatures:**

Student  (Recommended at age 14)  \_\_\_\_\_ Date \_\_\_\_\_

Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Witness \_\_\_\_\_

**\* \* \* Request to Revoke Statement below. \* \* \***

**\* \* \* Request to Revoke \* \* \***

I understand that I may revoke this authorization at any time by giving written notice to the Millinocket School Department using this form or any other written statement. This will not affect information released prior to receiving my request to revoke. I understand that revoking this authorization may be the basis for denial of health benefits or other insurance coverage benefits.

**My signature below officially revokes this authorization:**

Student  (Recommended at age 14)  \_\_\_\_\_ Date Revoked \_\_\_\_\_

Authorized Representative \_\_\_\_\_ Date Revoked \_\_\_\_\_

Relationship to Client \_\_\_\_\_

Witness \_\_\_\_\_

1<sup>st</sup> Reading: February 9, 2010

Adoption: March 9, 2010