Staff Use Only
☐ Acadia Hospital Corp.
AND / OR
☐ Acadia Healthcare, Inc.
268 Stillwater Avenue, PO Box 422
Bangor, Maine 04402-0422
Staff Assisting Patient: _____

Patient Name:

Patient DOB:

Patient MRN:

Authorization to Release or Obtain Health Care Information

Health Information Services Fax 207-973-6822

I, _____, hereby authorize Acadia Hospital / Healthcare (circle one) to release and/or obtain my below-designated health care information to and/or from:
Patient / Guardian Name

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

Agency / Individual: _____
Street _____ City or Town _____ State/Zip _____
Authorization by FAX to # _____ Attn: _____

I authorize Acadia to **RELEASE** all of my relevant health care information (including information created after I sign this form) to the Agency/Individual identified above, **EXCEPT (check only those items you do NOT want released):**

☐ Date of admission/discharge
☐ Admittance history
☐ Progress notes
☐ Referral form
☐ Diagnosis information
☐ Discharge summary
☐ Medical consult
☐ Verbal communication
☐ Diagnostic tests/result
☐ Service dates from _____ to _____
☐ Other excluded information

_____

I authorize Acadia to **OBTAIN** all of my relevant health care information (including information created after I sign this form) from the Agency/Individual identified above, **EXCEPT (check only those items you do NOT want obtained):**

☐ Date of admission/discharge
☐ Admittance history
☐ Progress notes
☐ Referral form
☐ Diagnosis information
☐ Discharge summary
☐ Medical consult
☐ Verbal communication
☐ Diagnostic tests/result
☐ Service dates from _____ to _____
☐ Other excluded information

_____

The purpose of this authorization is _____.


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If I wish to review this information prior to its release, I will check this box ☐. Review must be supervised (utilize Supervision of Review of Psychiatric Records form). If I have been diagnosed or treated for any of the following, I understand that Acadia needs my specific consent to disclose related information. I may cross out any of the following which do not apply. In no event may any such information, if applicable, be disclosed without my specific consent. This authorization expires in one year unless I specify an earlier expiration date.
Expiration Date (if any): _____

1. I DO ☐ DO NOT ☐ authorize **disclosure** of information about treatment or diagnosis of drug or alcohol abuse (Federal drug & abuse regulations, 42 CFR 2.31) including information within this category that is created after I sign this form. Such information may not be re-disclosed by the recipient without my specific written consent.
2. I DO ☐ DO NOT ☐ authorize **disclosure** of information about mental health treatment or diagnosis including information within this category that is created after I sign this form.
3. I DO ☐ DO NOT ☐ authorize **disclosure** of information which refers to treatment or diagnosis of HIV infection, ARC or AIDS including information within this category that is created after I sign this form. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships.
4. I DO ☐ DO NOT ☐ authorize Acadia to **obtain** information about treatment or diagnosis of drug or alcohol abuse (Federal drug & abuse regulations, 42 CFR 2.31) including information within this category that is created after I sign this form. Such information may not be re-disclosed by the recipient without my specific written consent.
5. I DO ☐ DO NOT ☐ authorize Acadia to **obtain** information about mental health treatment or diagnosis including information within this category that is created after I sign this form.
6. I DO ☐ DO NOT ☐ authorize Acadia to **obtain** information which refers to treatment or diagnosis of HIV infection, ARC or AIDS including information within this category that is created after I sign this form. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships.

I understand that the Provider will not condition treatment on signing this authorization. The Provider will not deny me treatment if I do not sign this form. I may review my record before signing. I may refuse to sign this authorization form. Partial or incomplete information will be labeled as such. I understand that if I refuse to sign this authorization form, it may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. I also understand that I may revoke this authorization at any time, except to the extent that any person or organization has acted in reliance on the authorization prior to receiving notice of revocation and except with respect to information already disclosed. I understand that if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage or benefits. To revoke my authorization, I will submit a written request to Acadia Health Information Services at the above address.

I understand that if information other than information about diagnosis and treatment for drug and alcohol abuse (see #1 above) is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

A copy of this form will be provided to me upon my request.

I understand the matters discussed on this form. I release the Provider, its employees, officers and trustees, medical staff members, and business associates from any legal responsibility, or liability for the disclosures of the above information to the extent indicated and authorized herein.

_____ _____
Signature of patient or guardian (signature requested for minors 14 or older) Date / Time

_____ _____
Signature of parent of minor, guardian or other legal representative Relationship

If you are faxing or mailing this form for guardian consent, please include a copy of court guardianship paperwork.

Admin Use Only

☐ Patient has a guardian other than parent of a minor
Confirmation of guardianship: date/source _____