



Authorization to Release and/or Obtain Information

Art of Awareness Provider: \_\_\_\_\_

Phone: 207-799-1331 FAX: 207-799-1350

Address: 100 Waterman Drive Suite 201 South Portland, ME 04106

Email: [clientservices.aoa@gmail.com](mailto:clientservices.aoa@gmail.com)

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

Address: \_\_\_\_\_

I hereby authorize the above Provider to release and obtain (verbally or in writing) information related to my medical and mental health treatment / history to the following individual, clinic staff, agency or institution:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Address: \_\_\_\_\_

I authorize the release of information, which is circled below:

- Evaluation/Assessment, Medical history, Treatment Status, Diagnosis, Psychological Test, Aftercare Plan, Treatment Plan, Psychosocial History, Discharge Summary, Other (Describe in Detail)

SOME INFORMATION IS SPECIALLY PROTECTED. IF YOU WANT ANY OF THE FOLLOWING INFORMATION TO BE SHARED, YOU MUST CHECK A BOX BELOW:

\_\_\_ I WANT any information about diagnosis and/or treatment of alcohol or drug abuse to be shared.

\_\_\_ I WANT any information about diagnosis and/or treatment of HIV/AIDS to be shared

This information is to be used for:

Restriction(s) on material revealed:

I understand that I can revoke (cancel) this authorization to disclose the above-referenced information at any time, except to the extent that disclosure has been made in reliance upon my authorization before revocation. I am aware that I can revoke my authorization in writing by addressing a letter to that effect to the above Provider; however, it will not be effective until the above Provider receives it.

This consent will expire thirty (30) months from the date hereof, unless I have previously revoked this consent, or unless I have specified a shorter period of expiration of this Consent, as follows: \_\_\_\_\_. I understand that I may receive a copy of the authorization.

Signature of Client or Guardian, Print Name, Date

Witness, Date