ART OF AWARENESS

Authorization to Release and/or Obtain Information

Art of Awareness Provider: _____

Address: 100 Waterman Drive, Suite 201, South Portland, Maine 04106 Phone: 207-799-1331 FAX: 207-799-1350

Email: clientservices@artofawareness.org Email (Intensive Outpatient Program): iop@artofawareness.org

Client Name: _____Date of Birth: _____

Home/Billing Address:_____

City:_____ State:_____ Zip Code:_____

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:_____

City:_____ State:_____ Zip Code:_____

I authorize the release of information, which is checked below: Billing related information ☐

Evaluation/Assessment ☐ Medical history ☐ Treatment Status ☐ Diagnosis ☐ Psychological Test ☐

Aftercare Plan ☐ Treatment Plan ☐ Psychosocial History ☐ Discharge Summary ☐

Other, please describe:_____

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.

Client or Guardian Signature:_____ **Date:**_____