OCMHS

Oxford County Mental Health Services
Release of Information

Client's Name: _____ DOB: _____

I do hereby consent to and authorize Oxford County Mental Health Services to:

☐ Disclose to and/or
☐ Obtain from

_____

Name of organization/person/facility

_____

Address, Telephone, Fax

INFORMATION PERTAINING TO: (check all that apply)

☐ Presence in treatment (including admission and discharge date)
☐ Treatment/Service Plan
☐ Diagnosis, brief description of progress and prognosis
☐ Discharge Summary
☐ Other specify:

☐ Intake and assessment (including medical/psychiatric history)
☐ Continuing care
☐ Chemical dependency treatment
☐ Medication
☐ Emergency Services

_____

For the Purpose of:

_____

I wish to review written information before it is released

☐ Yes
☐ No

Should my record contain information which refers to diagnosis or treatment of HIV, ARC or AIDS, I do / do not (circle one) authorize disclosure of this information.

I understand that the information indicated above is protected by law and cannot be released without my written permission unless otherwise required by law. I understand that I do not need to sign this form in order to receive services. I further understand that this authorization automatically expires as of: _____ (not to exceed 12 months) from the date of my signature or upon my request. I understand this information can be shared throughout the agency on a need to know basis.

Advisories: You may refuse to sign this authorization to disclose some or all of your healthcare information, but you should be aware that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, or other insurance or other adverse consequences. You may revoke this authorization at any time.

150 Congress Street
Rumford, Maine 04276
Phone: 364-3549
Fax: 364-2143

17 Gary Street
South Paris, Maine 04281
Phone 739-7001
Fax: 743-2999

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For Persons/Organizations Receiving Mental Health Information:
This information has been disclosed to you from records protected by State confidentiality rules (34-B M.R.S.A. Section 1201: Rights of Recipients of Mental Health Services). 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.

For Persons/Organizations Receiving Substance Abuse 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 alcohol or drug abuse patient.

_____ Date: _____
Client Signature / Legal Guardian

_____ Date: _____
Witness Signature

You are entitled to a copy of this authorization.

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