Authorization to Release Information

I, _____, date of birth: _____, hereby authorize

White Pine Behavioral Health LLC, Joel Guarna, PhD, Manager and Licensed Psychologist, at 25 Middle Street, Portland, ME 04101. Phone: 207-272-8500. Fax: 207-773-7386.

or his associated staff to **release / receive** protected health information **to / from**:

_____ Phone: _____

_____ Fax: _____

_____ _____

The types of protected health information that may be released include:

_____ Results of evaluations _____ Diagnostic Impressions _____ Other medical records

_____ Treatment Plans _____ Progress Notes _____

This protected health information is being used or disclosed for the following purpose:

_____

This authorization will remain in effect for 24 months from the date on this form unless otherwise specified.

Restrictions on release: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Joel Guarna, PhD at the address above. Revocation will be effective as of the date received. I understand that a revocation is not effective to the extent that Dr. Guarna has relied on the use or disclosure of the protected health information prior to the revocation date. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Dr. Guarna will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent that the state law provides better access rights). I understand that I have the right to refuse to sign this authorization.

_____ _____ _____

Signature of patient/parent/guardian or legal representative | Name (please print clearly) | Date

State and federal laws require my specific consent to disclose information pertaining to HIV testing or treatment, mental health treatment, and/or substance abuse treatment information. I authorize the release of such information with my signature below.

_____ _____

Signature of patient/parent/guardian or legal representative | Date