Brian W. Selby, Ph.D. PH: 207-299-2442 E-mail: DoctorSelby@hushmail.com
Christine L. B. Selby, Ph.D., CEDS PH: 207-299-2552 E-mail: DrChristineSelby@hushmail.com
6 State Street, Suite 502
Bangor, Maine 04401

Authorization for Release of Information

Name: ____ **Date of Birth:** ____________________________

Address: ______________________________________ **City, State, Zip:** __________________________

I authorize Selby Psychological Services to release information to and receive information from:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

__________________________________ __________________________________
Phone (Include area code) **Fax (Include area code)**

I understand that health care information is confidential and will not be released without my authorization unless permitted by law. I understand that I have the legal right to refuse authorization to disclose all or some health care information, but refusal may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

I understand that by law, Selby Psychological Services is required to release the minimum amount of information necessary to carry out the purpose of this release. Selby Psychological Services is only able to release information which it has generated.

PURPOSE OF THIS REQUEST: (check one) ☐ **Service Coordination** ☐ **Insurance Coverage** ☐ **Treatment Planning**

☐ **Other** ____________________

TYPE OF RECORDS AUTHORIZED: ☐ **Psychiatric/Psychological Evaluation and/orTreatment**
☐ **Drug/Alcohol Evaluation and/orTreatment**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Laboratory Test Results:** ______________________________

☐ **Diagnostic Impression** ☐ **Discharge Summary** ☐ **Treatment Plans**

☐ **Treatment Summary**

☐ **Other: (**please describe) ____

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified. **My authorization will expire:**
☐ When the requested information has been sent/received.
☐ 90 days from this date. ☐ Other: ____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.
My authorization will expire:
☐ When I am no longer receiving services from Selby Psychological Services.
☐ 12 months from this date. ☐ Other: ____________________________________

Patient Name:____

I understand that the party(ies) listed in Section 1 of this authorization need(s) my specific consent to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment.

I DO authorize the release of any information, which refers to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization **unless I initial here ____________.**

I DO authorize the release of information, which refers to the diagnosis or treatment of MENTAL HEALTH under this authorization **unless I initial here _____________.**

I DO authorize the release of any information, which refers to the testing, diagnosis or treatment of HIV/AIDS **unless I initial here ______________.**

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- Information released by Selby Psychological Services may be further released by the receiving party and that if this occurs, Selby Psychological Services cannot guarantee the protection of this information once disclosed.
- There may be a charge of the requested records. Please see the Outpatient Services Contract required by Selby Psychological Services for more information.
- I have a right to review mental health records prior to the disclosure of said records. It is recommended that this be supervised by a psychologist of Selby Psychological Services as this information may result in uncomfortable affective reactions.
- I authorize the party(ies) listed in this form to make subsequent disclosures to the same recipient pursuant to this authorization.
- I have a right to request a copy of this authorization.

My signature below indicates that I have read this release form, understand what this form authorizes, consent to the release of information, and have had all of my questions answered if any.

Signature of Patient or Representative: ______________________________________ Date: ________________

Relationship to Patient (*if requester is not the patient*): ☐ Parent ☐ Legal Guardian ☐ Other: ________________________

Signature of Selby Psychological Services Psychologist (Witness) ____________________ Date: _______________

Patient or Representative has been **provided/declined** a copy of this authorization:____________________________________

Psychologist providing copy

<u>**Revocation Statement and Revocation of Authorization**</u>

I have the right to revoke this authorization verbally, or in writing, at any time. Revocation will not cover information/material released prior to that date but will prevent further release of information. I understand that revocation may result in denial of insurance coverage or other adverse consequences.

By signing and dating below I revoke my authorization for all future release of information by Selby Psychological Services:

Signature of Patient or Representative: ______________________________________ Date: ________________

Relationship to Patient (*if requester is not the patient*): ☐ Parent ☐ Legal Guardian ☐ Other: ________________________

Signature of Selby Psychological Services Psychologist (Witness) ____________________ Date: _______________