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AUTHORIZATION TO RELEASE INFORMATION

NAME of patient / examinee _____ DOB _____

I hereby authorize

Dr. Andrew Wisch

(Mark the appropriate box)

To DISCLOSE to: and/or To OBTAIN from:

Name of Person or Organization _____

Address _____

Fax #: _____ Phone # to verify: _____

(Include fax number and phone number to verify receipt ONLY if fax is being used)

INFORMATION TO BE DISCLOSED

CHECK YES or NO for each of the following and specify the information being requested in the blank:

___ YES ___ NO Alcohol and/or Drug Treatment _____

(NOTE: Authorization is required to share ANY information about alcohol/drug treatment, whether spoken or written)

___ YES ___ NO Assessments _____

___ YES ___ NO Crisis Plans/Emergency Services _____

___ YES ___ NO Discharge Summaries _____

___ YES ___ NO Laboratory/Diagnostic Reports _____

___ YES ___ NO Medical History and/or Physicals _____

___ YES ___ NO Outpatient Treatment _____

___ YES ___ NO Psychiatric History and Evaluations _____

___ YES ___ NO Psychological and/or Psychosocial History, Reports, Evaluations _____

___ YES ___ NO Service/Treatment Plan(s) _____

___ YES ___ NO Other _____

PURPOSE FOR DISCLOSURE

CHECK YES or NO for each of the following:

___ YES ___ NO To help with the completion of a court-ordered evaluation

___ YES ___ NO To provide information relevant to treatment and/or continuity of care

___ YES ___ NO Other (specify) _____

INITIAL (instead of check) YOUR RESPONSE to EACH of the following statements:

___ I DO ___ I DO NOT authorize disclosure of information that refers to treatment or diagnosis of alcohol or drug abuse. I understand that it cannot be re-disclosed without my specific consent.

___ I DO ___ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of HIV or AIDS. I understand that some individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, insurance, or social/family relations.

___ I DO ___ I DO NOT wish to review, prior to its release, any information I have authorized for release.

I understand that the information indicated is protected by law and cannot be released without my written permission, unless otherwise specifically permitted by law. I understand that I have the right to review information and material released. I understand I have the right to revoke this authorization in writing at any time and that I may receive a copy of this authorization if I wish. The benefits, risks, and consequences of releasing or not releasing this information have been explained to me.

Examinee Signature or Mark

Date

Witness Signature

Date

Guardian/Parent/Legal Representative Signature (specify role)

Date

This authorization is effective until _____ (Date not to exceed 90 days)

Revocation of this Authorization:

Signature/Mark Of Person Revoking Authorization

Relationship

Date

Witness Signature (if Mark/Stamp above)

Witness Printed Name

Date

Additional Information for Persons/Organizations Receiving either Substance Abuse or Mental Health Information

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.

For Persons/Organizations Receiving Mental Health Information:

This information has been disclosed to you from records protected by State confidentiality laws (34-B M.R.S.A. §1207; 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.