DANIEL R FILENE, MD
178 MIDDLE ST, PORTLAND ME 04101
PHONE/FAX (207) 774-0046

Authorization to Release Confidential Information

Client Name: _____ DOB: _____

I, _____ hereby authorize Daniel R Filene, MD:
(Client/Guardian)

To RECEIVE the following information: --AND/OR-- *(Please check the appropriate box(es))*	**To DISCLOSE the following information:** *(Please check the appropriate box(es))*
☐ Any and all information relating to my care and treatment by the below-named provider	☐ Any and all information relating to my care and treatment by Daniel R Filene, MD
☐ **Only** the following information: ☐ Demographics ☐ Assessment ☐ Progress Notes ☐ Treatment Plan ☐ Discharge Summary ☐ Other (Please specify)	☐ **Only** the following information: ☐ Demographics ☐ Assessment ☐ Progress Notes ☐ Treatment Plan ☐ Discharge Summary ☐ Other (Please specify)

Information to be RECEIVED FROM/DISCLOSED TO:

Name: _____ Company: _____

If I have been diagnosed and/or treated for any of the following, I understand that Dr. Filene needs my explicit consent to disclose information related to the diagnosis or treatment. This information, if applicable, absolutely may not be disclosed without my explicit consent.

I DO ☐ **I DO NOT** ☐ authorize disclosure of information which refers to treatment of diagnosis of drug or Alcohol abuse
I DO ☐ **I DO NOT** ☐ authorize release of any information that may relate to diagnosis/treatment for HIV, ARC, or AIDS.
I DO ☐ **I DO NOT** ☐ authorize release of any information that may relate to mental health treatment.

I authorize the above-named provider to make subsequent disclosures to the same recipient pursuant to this authorization. **Unless earlier revoked, this consent expires in 90 days or on the following date not to exceed one (1) year.** ***Specified date:*** _____

I waive my right to review this information prior to its disclosure:	☐ Yes ☐ No
I authorize the provider to send/receive these records by fax:	☐ Yes ☐ No

I understand that I may refuse to release some or all of the information in the provider's records, but that such refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or insurance, or other adverse results. Dr. Filene will NOT release health information generated by other providers or facilities. Statements added to records by clients and/or guardians will not be released without written consent. I understand that if the above listed information is disclosed, it is possible that it may be redisclosed by the recipient, or that it may not longer be subject to confidentiality protections.

I understand the matters discussed on this form. I release Daniel R Filene, MD from any legal responsibility or liability for the disclosures of the above information to the extent indicated and authorized herein.

I understand that I may revoke this authorization at any time by giving written or verbal notice Daniel R Filene, MD. This will not affect information released prior to receiving my request to revoke.

Client:_____ **Date:** _____

OR: Authorized Representative: _____ **Date:** _____

Relationship to Client: _____

Witness: _____ **Date:** _____