Ellen H. Theodores, LCSW, LLC
153B Park Row
Brunswick, ME 04011
207 245-5087

Authorization for Release/Request of Confidential Information/PHI

I, _____, hereby authorize Ellen H. Theodores, LCSW, LLC to release or obtain protected health information ("PHI"):

_____release to: _____

_____obtain from: _____

The following:

_____Information regarding my comprehensive assessment
_____Information about recommendations and treatment plan
_____Information about general progress
_____Information regarding my current work or personal life circumstances
_____Other information regarding: _____

This information is needed for the purpose of: _____

If I have been diagnosed or treated for any of the following, I understand that my specific consent to disclose related information is required.

1. I (**__Do __Do Not)** authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse.
2. I **(__Do __Do Not**) authorize disclosure of information which refers to treatment or diagnosis of mental health.
3. I **(__Do __Do Not**) authorize disclosure of information which refers to HIV test results, infection status or treatment information.
4. I **(__Do __Do Not**) want to review this information before it is released. I understand that such reviews must be supervised.

I hereby relieve and release the above-mentioned from any and all damages, claims and courses of action arising out of, or in connection with the release of this information.

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing and received by: Ellen H. Theodores, 153B Park Row, and Brunswick, ME 04011. Some exceptions apply, for more details on when I can and cannot revoke this authorization; I can read Ellen H. Theodores' Notice of Privacy and Practices. If not previously revoked, this consent will otherwise expire on:

_____
(Date, Event or Condition)

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Maine law may protect such information.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Representative Date

_____
Relationship to Patient or Description of Authority to Act for patient