251 Woodford Street Phone: (207)749-2343 Fax: (207)761-8150

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize Dr. Jennifer Blanchette, New Life Counseling ______________ to release healthcare information of the patient named above to

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

Phone:______________ Fax______________ Email:______________________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information ☐ Intake ☐ All healthcare information

☐ Other: ____

☐ Yes ☐ No I authorize the release of my STD status, HIV/AIDS status, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug/alcohol treatment to the person(s) listed above.

Patient Signature: ______________________________ Date Signed: ______________________

Parent/Guardian
(under 18)
Signature: ______________________________ Date Signed: ______________________

Witness Signature:______________________________ Date Signed:______________________

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED.