HEALTH AFFILIATES MAINE

Consent to Use Health Care Information

Client Name: ____

Client #: _______

Clinician Name: __Allison H. H. Thompson, MSW, LCSW, CADC____________________

I understand that Health Affiliates Maine will make use of my health care information for purposes of treatment and other lawful functions of Health Affiliates Maine's practice, including securing payment and other usual health care operations. I understand that this information may be available to person working on Health Affiliates Maine's behalf, who will be subject to the same duty of confidentiality as Health Affiliates Maine with respect to any of my information.

I understand that if Health Affiliates Maine holds certain sensitive information related to my health care, such as:

- Records covered by Federal rules governing confidentiality of alcohol and drug abuse treatment programs
- Records covered by State rules governing mental health services
- Records concerning my, or my child's diagnosis or treatment for HIV or AIDS

then my specific authorization will be required to disclose such information to others. However, I consent to use of such information by Health Affiliates Maine as detailed above. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

Signatures

Client (14 years and older): __________________________________Date: ___/___/___

Parent/Guardian: ____Date: ___/___/___

Witness: Allison H. H. Thompson, MSW, LCSW, CADC Date: ___/___/___