CATHOLIC CHARITIES MAINE



## Education Services for Blind and Visually Impaired Children

**420 Cumberland Avenue, Portland, ME 04101**

**AUTHORIZATION TO DISCLOSE INFORMATION**

Client Name: Client Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that a copy of this form will be released with my records.**

Catholic Charities Maine may **RELEASE TO CDS/School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Information pertaining to:  **Eye Condition/Most recent eye exam report**  **Education**  Do  Do Not include health records from other sources. | Information for the following purposes:  **Service to my child**  **Service to my child** |

Catholic Charities Maine may **OBTAIN FROM:**

**School/CDS name:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Information pertaining to:  **Eye Condition/Most recent eye exam report**  **School/Work concerns**  Do  Do Not include health records from other sources. | Information for the following purposes:  **Services from ESBVIC**  **Services from ESBVIC** |

**This Authorization expires automatically upon the following case, event or condition (not to exceed one year): Date:\_\_\_\_\_\_\_\_**

Required Statements: I understand that: (1) CCME cannot withhold treatment if I refuse to sign this Authorization, unless it relates to research-related treatment or treatment provided solely to create and disclose health information to a third party; (2) I may review my records prior to release and refuse to disclose some or all of them; (3) I may revoke all or part of this Authorization at any time by notifying CCME as provided in its Notice of Privacy Practices, except to the extent that action has already been taken in reliance on this Authorization; (4) In some cases a refusal or revocation may result in improper diagnosis or treatment, denial of insurance coverage or other similar consequences; (5) A disclosure of information carries with it the potential for re-disclosure if the recipient is not subject to the state or federal confidentiality rules; and (6) I may have a copy of this Authorization.

**Release: I hereby release CCME from all liability and all claims relating to the release of this information.**

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Personal Authorized Representative Print Name

Specify Relationship for Authorized Representation

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Print Name