Katherine Kessler, D.O.
22 Free St. Suite 207
Portland, Maine 04101
Phone: (207) 536-8511
FAX 888-974-0335

Authorization for Disclosure
Personal Health Information (PHI)

Client name: _____ Date of Birth: _____

I, _____, hereby authorize Katherine Kessler, D.O. to ___disclose to OR ___ obtain from the following individual or organization personal health information about me or the individual named above:

Name of Individual or Position Title	Name of Organization	Mailing Address	Telephone Number
_____	_____	_____	_____

Please check "yes" or "no" next to the following items to indicate the information that you wish to have disclosed:

Yes	No	
__	__	All of my mental health treatment information, including dates and summary of treatment history
__	__	Records on file from third party sources, specifically: _____
__	__	Statements I have added to my treatment records.
__	__	Other _____

Please check "yes" or "no" next to the following statements:

Yes	No	
__	__	I want to review this information before it is disclosed. I understand that any such review will be performed with my worker or a designated staff member.
__	__	I authorize the disclosure of information relating to the diagnosis or treatment of alcohol or drug use. I understand that such information should not be re-disclosed by the recipient without my specific consent.
__	__	I authorize the disclosure of information relating to the diagnosis, treatment or testing for HIV.
__	__	I authorize the provider to send these records by fax.

Please check "yes" or "no" next to purpose of this disclosure:

Yes	No	
__	__	Provision of ongoing treatment or after care
__	__	Coordination of treatment efforts with family/concerned other(s)

Date this authorization will expire: _____ (not to exceed 12 months for ongoing disclosure of information)
Unless earlier revoked or otherwise specified above, this authorization will expire 12 months from the date signed.

By signing below, I acknowledge that the benefits, risks, and consequences of the alternatives in disclosing or not disclosing this information have been explained to me. I have the right to receive a copy of this authorization. I also understand that:

- I can refuse to disclose some or all of the information in my record, and I may cross out any words on this form with which I disagree, though either action may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, or other adverse consequences.
- Information received by Katherine Kessler. will not be re-disclosed without my specific consent.
- If information is disclosed pursuant to this authorization, it is possible that it may be re-disclosed by the recipient, or that it may no longer be subject to confidentiality protections.
- Refusal to disclose will not cause Katherine Kessler, D.O.. to deny services unless Dr. Kessler. is providing treatment solely for purposes of creating information for a third party to whom the information is to be disclosed.
- I may revoke this authorization at any time by giving written or verbal notice of revocation to Dr. Kessler.

Client Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Basis for Representative's Authority: __ Parent __Guardian __Other (specify) _____

Witness Signature: _____ Date: _____