Maine Mental Health Information Disclosure Consent Form

Client Information:
Name: _____
Date of Birth: _____

I, the undersigned, hereby consent to the disclosure of my mental health information as described below:

1. **Purpose of Disclosure:**
   The mental health information will be disclosed for the following purposes (check all that apply):
   ☐ Collaborative care with another healthcare provider
   ☐ Coordination of care with mental health professionals
   ☐ Treatment planning and/or follow-up
   ☐ Other (please specify): _____

2. **Information to be Disclosed:**
   I consent to the disclosure of the following mental health information (check all that apply):
   ☐ Mental health treatment notes
   ☐ Diagnosis or assessment information
   ☐ Progress notes
   ☐ Psychiatric history
   ☐ Other (please specify): _____

3. **Recipient(s) of the Information:**
   The following individuals or entities may receive my mental health information:
   ☐ Therapist/Counselor: _____
   ☐ Psychiatrist: _____
   ☐ Primary Care Provider:
   _____
   ☐ Other (please specify): _____

4. **Expiration of Consent:**
   This consent is valid until (date or event): _____ or until revoked by me in writing. If no expiration date is provided, this consent will expire one year from the date signed.

5. **Revocation of Consent:**
   I understand that I may revoke this consent at any time by providing written notice to the healthcare provider. Revocation will not affect any disclosures that have already been made in reliance on this consent.

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6. **Risks and Limitations:**
   I understand that once my mental health information is disclosed to the recipients above, it may no longer be protected by the privacy laws and may be subject to further disclosure without my consent. However, I also understand that the recipients are legally obligated to protect my mental health information to the extent possible.

7. **Acknowledgment and Understanding:**
   I have been informed of the purpose and scope of this consent and understand my rights regarding the privacy and disclosure of my mental health information. I understand that I do not have to sign this consent to receive care.

Signature of Client (or Legal Representative):
Signature: _____
Date: _____

Legal Representative (if applicable):
Name:
_____
Relationship to Client: _____

Covered Entity Representative (if applicable):
Name: _____
Title: _____
Signature: _____
Date: _____