



# The Margaret Murphy Centers for Children

[www.margaretmurphycenters.org](http://www.margaretmurphycenters.org)

## John F. Murphy Homes

800 Center St.  
Auburn, ME 04210  
Phone: (207) 782-2726

### MMCC Locations:

27 Charles St.  
Auburn, ME 04210  
Phone: (207) 786-7708  
Fax: 1-8(833)839-2862

24 Falcon Dr.  
Auburn, ME 04210  
Phone: (207) 333-3382

1520 Hotel Rd.  
Auburn, ME 04210  
Phone: (207) 376-3022  
Fax: (844) 836-8951

1371 Minot Ave.  
Auburn, ME 04210  
Phone: (207) 330-4877  
Fax: 1-(888)965-8961

415 Rodman Rd.  
Auburn, ME 04210  
Phone: (207) 376-3022  
Fax: (844) 836-8951

655 Main St.  
Lewiston, ME 04240  
Phone: (207) 376-3311  
Fax: 1-(833) 341-1424

5 Memorial Ave.  
Lewiston, ME 04240  
Phone: (207) 344-0900  
Fax: (833) 381-0952

17 School St.  
Randolph, ME 04346  
Phone: (207) 588-2699  
Fax: (833) 836-4894

60 Industrial Park Rd.  
Saco, ME 04072  
Phone: (207) 494-7304  
Fax: (844) 689-9674

## CONSENT TO DISCLOSE OR OBTAIN CONFIDENTIAL INFORMATION

Name of Client: \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize the Margaret Murphy Centers for Children, its authorized employees and agents, via verbal exchange, hard copy or electronic transmittal, to (check appropriate boxes)

- Obtain written medical/clinical/educational records and information from:
- Disclose written medical/clinical/educational records and information to:

Organization/Individual: \_\_\_\_\_  
 Relationship (if individual) \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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 Relationship (if individual) \_\_\_\_\_  
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 City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

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 Relationship (if individual) \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

The medical/clinical/educational records and information include the following:

- All information, including history, dates, course and outcome of treatment, all items below and any other information
- Only the following information which is checked:
  - Discharge Summary  Assessment  Support Plan  Quarterly Review
  - Psychological Evaluation  Diagnosis  State & Local Academic Assessments
  - Other Records (be specific): \_\_\_\_\_

1.  I DO  I DO NOT authorize information which refers to treatment of diagnosis of alcohol or drug abuse to be disclosed or obtained.  
**IMPORTANT: IF #1 is checked "I DO," then the client, regardless of age, MUST sign this consent.**
2.  I DO  I DO NOT authorize information concerning diagnosis and treatment of mental health conditions to be disclosed or obtained.
3.  I DO  I DO NOT authorize information which refers to treatment or diagnosis of HIV infection or AIDS to be disclosed or obtained.
4.  I DO  I DO NOT wish to review written information prior to its being disclosed or obtained.
5.  I DO  I DO NOT want a copy of this release.





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The records and information are to be provided or obtained for the purposes of: (check all appropriate boxes)

- Ongoing Treatment
- Aftercare Treatment
- Educational
- Legal
- Financial
- To Coordinate Treatment Efforts
- Other (be specific)

I understand that

- I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, or denial of coverage or of a claim for health benefits/other insurance, or other adverse consequences.
- MMCC's provision of services does not depend on my giving this consent.
- Any records and information disclosed to a recipient outside MMCC may potentially be re-disclosed and no longer be protected by Federal or State law.
- I may revoke this authorization at any time either verbally or in writing. A revocation does not apply to any actions previously taken in reliance on my consent, including disclosures already made or services already rendered. I understand that by revoking my consent that it may result in denial of insurance coverage or other adverse consequences.

This consent is effective until \_\_\_\_\_ . (Maximum is one year for mental health services, and ninety days for one-time disclosures.)

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Staff Signature and Title: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

### FOR STAFF USE ONLY

Was a copy of this consent given to Parent/Guardian?  YES  NO

If copy given, please enter date: \_\_\_\_\_

Information requested by (outside MMCC): \_\_\_\_\_ Date: \_\_\_\_\_

MMCC records sent by (initials of person sending): \_\_\_\_\_ Date: \_\_\_\_\_

RELEASE REVOKED (date): \_\_\_\_\_ By Whom (name): \_\_\_\_\_

Name of Staff member noting revocation of release: \_\_\_\_\_

