John F. Murphy Homes

800 Center St.
Auburn, ME 04210
Phone: (207) 782-2726
Fax: (207) 782-1734

MMCC Locations:

27 Charles St.
Auburn, ME 04210
Phone: (207) 786-7708
Fax: (844) 886-3944

Fairview Elementary School
397 Minot Ave.
Auburn, ME 04210
Phone: (207) 784-3559
Fax: (207) 786-0787

24 Falcon Dr.
Auburn, ME 04210
Phone: (207) 333-3382
Fax: (207) 333-3369

Geiger Elementary School
601 College St.
Lewiston, ME 04240
Phone: (207) 795-4160
Fax: (207) 753-6409

1371 Minot Ave.
Auburn, ME 04210
Phone: (207) 330-4877
Fax: (207) 330-4879

655 Main St.
Lewiston, ME 04240
Phone: (207) 376-3311
Fax: (207) 786-7277

180 Mt. Auburn Ave.
Auburn, ME 04210
Phone: (207) 241-0085
Fax: (207) 241-0144

415 Rodman Rd.
Auburn, ME 04210
Phone: (207) 376-3022
Fax: (207) 376-3039

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:** _____

Organization/Individual: _____
Relationship (if individual) _____
Street Address: _____
City/State/Zip: _____ **Phone:** _____

Organization/Individual: _____
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, <u>regardless of age</u>, 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.

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: _____