Consent & Notice of Privacy Practices

Acknowledgement of Receipt

Client Name:____

Provider Name: Allison H. H. Thompson, LCSW, CADC

I understand that it is Health Affiliates Maine's policy to treat all protected healthcare information and records as confidential, and not to disclose such information unless authorized to do so. Health Affiliates Maine will use my information for the purposes of treatment, securing payment and other usual operations. I understand that this information may be available to people working on behalf of Health Affiliates, who are subject to the same duty of confidentiality with respect to any of my information. I understand that I have certain rights with respect to disclosure of my health care information, subject to certain disclosures that are permitted or required by law (as fully described in the Notice), for example:

- I have specifically authorized the disclosure
- The disclosure is permitted or required by law
- Reports of homicidal or suicidal intent with a plan
- Mandated reporting of suspected or known abuse or neglect of a child or incapacitated or dependent adult

I understand that if Health Affiliates Maine holds certain sensitive information related to: alcohol and drug abuse treatment programs, mental health treatment, and/or diagnosis or treatment for HIV or AIDS; then special authorization will be required to disclose this information to others. I understand that I may refuse to allow the sharing of some or all such information, but the refusal may result in improper diagnosis or treatment or other adverse consequences.

My records will be maintained for six (6) years beyond discharge (or 6 years after the age of 18 after discharge). I can request copies of my record during the time my record is maintained.

I also acknowledge that my services are provided to me through Health Affiliates Maine, a licensed behavioral health agency. Should my provider discontinue working through Health Affiliates Maine, Health Affiliates Maine will arrange for continuation of services through another provider, if I desire. I further understand that Health Affiliates Maine is responsible for the services that are provided to me, and I can contact Health Affiliates Maine at any time with questions or concerns about my treatment at 207-333-3278.

I acknowledge that I have received a copy of Health Affiliates Maine's "Notice of Privacy Practices", and I have been given an opportunity to review this notice.

Signatures:

Client (14 years and older)____Date____________

Authorized Representative____Date____________

Relationship to Client____

Witness: Allison H.H. Thompson, MSW, LCSW, CADC

Health Affiliates of Maine, LLC use only: if this form is not signed/dated by the patient/legal representative

I have made a good faith effort to obtain a written acknowledgement of receipt of Health Affiliates of Maine, LLC's Consent and Notice of Privacy Practices but was unable to for the following reason:

☐Patient refused to sign ☐Patient unable to sign ☐Other ______________________________

____ ________________

Health Affiliates Maine Staff/Affiliate Name Date