Summit Achievement

69 Deer Hill Road, Stow, ME, 04040. (207) 697-2020

Authorization to Release Information

I hereby authorize Summit Achievement to use or disclose the information described below, only for the purposes and parties also described below.

Parent or legal guardian:____

With whom may Summit share information about your child?:_________________________________

____

____

Specific information to be shared or disclosed: (clinical, medical, academic, etc.)

____

____

____

This information is being requested for the following purpose(s):(admissions, clinical, medical, academic, etc)

____

____

____

This authorization shall remain in effect from the date signed below for a period six months or until ____________(expiration date or event).

I understand that:

- I may inspect or copy the protected information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

Client Name:____

Parent/Legal Guardian Name:(print)____

Parent/Legal Guardian Signature:____

Date:____