**Island Institute for Trauma Recovery, LLC**
**110 Main Street, Suite 1200**
**Saco, Maine 04072**
**207-571-3008**

## Consent to Use Health Care Information

**Client Name:** _____

**Client #:** _____

I understand that Island Institute for Trauma Recovery, LLC will make use of my health care information for purposes of treatment and other lawful functions of Island Institute for Trauma Recovery, LLC practice, including securing payment and other usual health care operations. I understand that this information may be available to persons working on Island Institute for Trauma Recovery, LLC behalf, who will be subject to the same duty of confidentiality as Island Institute for Trauma Recovery, LLC with respect to any of my information.

I understand that if Island Institute for Trauma Recovery, LLC holds certain sensitive information related to my health care, such as:

- Records covered by Federal rules governing confidentiality of alcohol and drug abuse treatment programs
- Records covered by State rules governing mental health services
- Records concerning my, or my child's diagnosis or treatment for HIV or AIDS

then my specific authorization will be required to disclose such information to others. However, I consent to use of such information by Island Institute for Trauma Recovery, LLC for purposes of my evaluation and treatment, and other lawful functions of Island Institute for Trauma Recovery, LLC practice, including securing payment and other usual health care operations. I understand that such information may be made available to persons working on Island Institute for Trauma Recovery, LLC behalf, who will be subject to the same duty of confidentiality as Island Institute for Trauma Recovery, LLC with respect to such information. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

**Signatures**

Client (14 years and older): _____Date: ___/___/___

Parent/Guardian: _____Date: ___/___/___

Clinician _____Date: ___/___/___

_____
Clinician name and credentials (Printed)