



## Authorization to Release Confidential Information

In order to participate in the Psychiatric Service Dog (PSD) Training Program, I understand I must be in treatment/therapy/counseling during the training process term of the program.

I, \_\_\_\_\_, authorize Maine Paws for Veterans, Inc. to disclose, receive and exchange information with (Therapist's name): \_\_\_\_\_.

The information to be disclosed may include treatment records, summary of treatment, attendance information, and other personal health information relevant to the relationship between myself and the services being provided by Maine Paws for Veterans.

The purpose of this release is to coordinate efforts with the mental health professional, myself and the Maine Paws for Veterans team.

I understand that my records are protected under Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it and acknowledge that the information released was fully explained to me and this consent is given of my own free will.

I understand that information used or disclosed pursuant to this authorization may be redisclosed by the recipient and no longer be protected by confidentiality laws.

This Authorization to Release Confidential Information becomes effective immediately and will expire on \_\_\_\_\_. (No more than one year)

Veteran Signature: \_\_\_\_\_ Date: \_\_\_\_\_