CMHC – Central Maine Medical Center
300 Main St., Medical Records
Ph# (207) 795-2480 Option #3 **Fax #:(207) 344-0674**

Date Received: _____
Request Type: _____.
MR #: _____.

Authorization to Release Medical Information

_____.
(Entered Stamp)

Patient Name: _____ **Date of Birth**: _____.
Address: _____ **Apt. #** _____.
City: _____ **State**: _____ **Zip Code**: _____ **Ph# (**) _____.

I hereby authorize the release of copies of my medical records concerning my illness, treatment or recommendations while I was a patient at the medical facility, **during the dates of:** _____.

These records should be released:

From:
Name: _____ Phone # (___) _____.
Address: _____ Fax# ___( ) _____.
_____.

To:
Name: _____ Phone # (____) _____.
Address: _____ Fax# (___) _____.
_____.

I request the following information be released:
____ Inpatient hospital record ____ ER/ First Care Visit ____ X-Rays or EKG ____ Lab/Path report
____ **Clinical Offices (specify)** _____ ____ Other (specify) _____ _____
____ Abstract (choose for personal use & continuation of care) ____ Complete Copy (used for legal purposes)

Please check the following specific authorizations: [Required by law]:

AIDS/HIV and other Communicable Disease	____ I DO authorize	____ I DO NOT authorize
Alcohol and/or Drug Abuse Treatment	____ I DO authorize	____ I DO NOT authorize
Mental Health Services	____ I DO authorize	____ I DO NOT authorize

(Mental Health Services Provided by: A clinical nurse specialist; Psychologist; Social Worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.)

The Purpose for releasing this information is:
____ Further medical Care Dr.'s Name and Fax# _____
____ Other (specify) _____ _____Transferring out: _____
(**Facility Transferring To)**

I understand I may revoke all or part of this authorization by notifying CMMC. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim for health benefits, or other adverse consequences. I may cross out any words on this authorization with which I disagree. I may have a copy of this authorization upon request. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. If I refuse to sign this authorization I understand my records will not be released.
This authorization will expire 90 days from the date I sign this form.

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to patient** **Date**

CMHC may take up to 30 business days to complete request.
Charges are as follows for the processing of medical records: Patients, first 5 pages are no charge, 6th page is $10 and , $0.35 per page following. All other agencies are as follows; $10.00 for first page and $0.35 per page following. Certified copy $30. Senior citizen discount: 100 pages or less no charge; $0.10 per page over 100. There are no charges for provider to provider care. We accept checks, money orders & credit cards. If picking up records please bring a photo ID.

**** For Office Use Only ****
Employee accepting request: _____ ID Checked ___YES ____ NO Amt. of payment received: _____
Request Completed: _____No _____**Yes: by whom:** _____ Date: _____