MaineHealth

144028

SHARED ELECTRONIC HEALTH RECORD

Patient Name: _____

Date of Birth: _____

Contact Phone: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize _____ **its authorized employees or agents**
(Individual / Organization making disclosure)

to release information from my health record and speak with relevant persons concerning this information.

Send to (Name and Address): _____

_____

Dates of Service: From _____ To _____

Specific Information to be released:

☐ Discharge Summary ☐ History and Physical ☐ ED Record
☐ Operative Report ☐ Pathology Report ☐ X-Ray Report
☐ Laboratory Reports ☐ Consult Report ☐ EKG
☐ Radiology Images ☐ Other (Specify): _____

I DO authorize the disclosure of any information relating to the diagnosis or treatment of **ALCOHOL or DRUG ABUSE**. If I authorize the release of this information, I understand that such information cannot be redisclosed by a recipient without my specific consent.	I DO NOT: _____(initial here).
I DO authorize the disclosure of any information relating to the diagnosis or treatment of **MENTAL HEALTH**	I DO NOT: _____(initial here).
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released.	I DO: _____ (initial here). I understand that such review must be supervised.
I DO authorize disclosure of information which refers to **HIV** test results, infection status or treatment information.	I DO NOT: _____(initial here).

This disclosure is for the purpose of: _____

I understand that

- I can refuse to disclose some or all of the information in my treatment records, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I understand I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written notice to the Health Information Management Department except where information has already been acted upon for the release of my protected health information.
- I can cross out any provision on this form with which I disagree.
- if information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be redisclosed by the person or entity that receives this information.
- this release may not include records generated at other facilities unless expressly requested above.
- I understand I am entitled to a copy of this authorization, upon request.

This authorization is effective for one year from the date of signing. I authorize future disclosures to the same individual and/or entities during this time period.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative Relationship and Date

_____ _____
Printed Name of Authorized Representative Witness

Information Released

Pgs___ Date: _____

Method:

☐ in person ➔ ☐ ID verified
☐ Fax ☐ Mail
☐ Paper ☐ Digital storage

Staff Initials _____

Pt. Initials _____

Original: Medical Record Copy: Patient