Spectrum MEDICAL GROUP

Send Requests to:
324 Gannett Drive, South Portland, ME 04106
Phone: 207.482.7800 Fax: 207.482.7898

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for use or disclosure of protected health information pertaining to:

Name of Patient_____

Address: _____

DOB:_____Phone: _____

I hereby authorize the following health care provider:
Provider Name: _____

Name/Address of Practice: Spectrum Medical Group formerly dba Medical Rehabilitation Associates

To *release* my protected health information to:

Name: _____

Address: _____

Via: ☐ ***Email*** ☐ ***Fax*** ☐ ***US Postal Service (Directly Handed to Patient)***
Purpose of disclosure: _____

[If practice is using PHI for marketing purposes, this must be stated & include if remuneration is involved]

Protected health information to be released:

☐ Medical records (specify, can state "all"):_____

☐ Billing records

Time frame: ☐ entire record ☐ records from_____(date) to_____(date)

Your specific permission is required to disclose information regarding the following:

Check box and sign on the lines provided to specify protected health information to be disclosed

☐ Treatment by Mental Health Professional or Program _____
Patient Signature
[Note to practice: this includes records generated at a mental health agency/facility or by a psychiatrist, clinical nurse specialist, social worker or psychiatrist records created by other physicians do not require specific authorization]

☐ Drug/Alcohol Abuse _____
Patient Signature
[Note to practice: this includes records generated by medical personnel whose primary function is providing alcohol or drug abuse diagnosis, treatment, or referral and who are identified as such providers, not general care providers]

☐ HIV Test Results or Status _____
Patient Signature
[Maine law requires our practice to inform you that, if this information is misused, disclosing your HIV infection status may have consequences, such as negative treatment in your personal life or by insurance companies. It can be important for providing you needed services & healthcare.]

If no date is given, this authorization is valid for **30 months** from signature date.

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- I understand that I am not required to sign this form and Medical Rehabilitation, a Division of Spectrum Medical Group, will not condition treatment, payment for services, or eligibility for services on whether I sign this form. I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences.
- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
- I understand that I have the right to access or copy the PHI described in this form by making a written request to the Privacy Officer of this practice. A copying fee may be charged as permitted by law.
- I understand that as a person receiving treatment in the State of Maine and/or as a resident of the State of Maine, if I refuse to disclose all of some health care information, my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse requirements.
- I understand that a revocation due to the above may be the basis for denial of health benefits or other insurance coverage or benefits.
- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer/Office Manager at Medical Rehabilitation, a Division of Spectrum Medical Group. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
- I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.
- I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.
- I understand that I have a right to receive a copy of this authorization.

Signed: _____ **Date:** _____

Print name: _____

If signed by other than patient, indicate legal relationship: _____