Maine Mental Health Partners
Spring Harbor Hospital & Spring Harbor Community Services
123 Andover Rd
Westbrook, ME 04092
(207) 761-2213 Phone
(207) 774-6762 Fax

Patient Name:

Patient Date Of Birth:

PATIENT NAME LABEL

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Maine Mental Health Partners/Spring Harbor Hospital, Spring Harbor Community Services and Maine Medical Center Mental Health Network, their authorized employees and agents to:

☐ Release medical records to:
☐ Obtain medical records from:
☐ Discuss with:
☐ Both release medical records to and discuss with:

Name _____ Street _____

City or Town _____ State / Zip _____

The following information:

☐ All information, including history, dates, course and outcome of treatment (indicate approximate dates)
☐ Only the following information which is circled (indicate approximate dates):

a. Discharge Summary
b. Medical Consultation
c. Diagnostic tests
d. Medical H & P
c. Psychiatric Evaluation
f. Psychosocial
g. Progress Notes
h. Outpatient Record
i. Patient Statements
j. Medication Information
k. Other Records _____

1. ☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. If I authorize the release of such information, I understand that it cannot be re-disclosed by a recipient without specific consent, and cannot be used against me in a criminal proceeding.
2. ☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.
3. ☐ I DO ☐ I DO NOT understand that I have the right to review this information at any reasonable time, including prior to its release. Review must be supervised (see reverse for documentation).
4. ☐ I DO ☐ I DO NOT authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARCS, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing education, life insurance, health insurance, and social and family relationships.

For purpose of:

☐ Ongoing Treatment / Aftercare:
☐ To coordinate treatment efforts with family / concerned others:
☐ At the request of the individual/patient
☐ Other (Specify): _____

I understand that

- I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I will not be denied treatment for failing to disclose information.
- I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated and signed notification to the Health Information Management Department except to the extent that Spring Harbor has already acted in reliance on it.
- I am entitled to a copy of this authorization, upon request.
- I can cross out any provision on this form with which I disagree.
- Recipients may not be subject to state and federal Privacy laws and therefore information may be re-disclosed without my consent.

This authorization is effective until _____ (or six months from the date below if I do not specify a date), and I authorize future disclosures regarding these records to the same individuals and/or entities during this time period.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative Relationship

_____
Witness

Information Released
_____
_____
_____
_____
_____
Date Released: _____
Initials: _____

THIS RELEASE MUST BE FILLED OUT COMPLETELY; PLEASE READ CAREFULLY