Maine Medical Center

Department of Health Information Management

AUTHORIZATION (1 YEAR) TO RELEASE MEDICAL INFORMATION AND RECORDS

144028

PATIENT NAME LABEL

I hereby request and authorize Maine Medical Center and its employees and agents to release any and all of the information contained in the medical record of and to discuss any information or medical opinions relating to the diagnosis, care and treatment of:

_____ _____ _____

Patient | Date of Birth | SS #

to the following agency/person:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Treated at:

☐ MMC Inpatient - Date(s): _____ ☐ Brighton - Date(s): _____

☐ Outpatient Clinic(s) - _____ ☐ Scarborough Surgical Center - Date(s): _____

Specify clinic & dates: _____ ☐ Employee Health - Date(s): _____

☐ Emergency - Date(s): _____ ☐ ASU - Date(s): _____

☐ Medical Records from other facilities or providers: _____ ☐ Statements I added to records/any responses

Other information to be disclosed: (specify) _____

Information that I refuse to disclose: (specify) _____

The purpose of the release: _____

I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all such information listed above, except those items I have specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. I understand that Maine Medical Center will not condition treatment, payment, enrollment or eligibility on my signing this authorization.

The authorization is valid for a period of 1 year from the date of signing. I further understand that I may revoke this authorization by written notice to the Director of Health Information Management at any time during this period except where the Maine Medical Center already has acted upon a request for the release of my medical record. I understand that revocation may be the basis for denial of health benefits or other health insurance coverage. For more details on when I can and cannot revoke this authorization, I can read Maine Medical Center's Notice of Health Information Privacy Practices.

I understand that if this 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.

If I have been diagnosed or treated for any of the following, I understand that Maine Medical Center needs my specific consent to disclose related information.

1. I (☐ **DO** ☐ **DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse.
2. A. I (☐ **DO** ☐ **DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of mental health.
   B. I (☐ **DO** ☐ **DO NOT**) want to review this information before its released. I understand that reviews must be supervised.
3. I (☐ **DO** ☐ **DO NOT**) authorize disclosure of information which refers to HIV test results, infection status, or treatment information.

I understand that I am entitled to a copy of this authorization form.

Signed: _____ Date: _____

Signed: _____ Date: _____

Authorized Representative

Relationship to Patient: _____

Witness: _____ Date: _____

I.D. Verified _____ By: _____