MaineGeneral Health
MaineGeneral Medical Center, MaineGeneral Rehab and Long Term Care, MaineGeneral Community Care

Authorization to Release Health Care Information

Name of Patient (please print):_____

Date of Birth of Patient: _____ Telephone: _____

I give permission for ☐ MaineGeneral Medical Center ☐ MaineGeneral Community Care

☐ MaineGeneral Medical Center Medical Practice _____
(Name of MaineGeneral Practice)

☐ MaineGeneral Rehabilitation and Long Term Care _____
(Name of Facility)

☐ To give information to **OR** ☐ To receive information from the person/place listed below:

Name _____

_____
Street City/Town State Zip Code

_____
Phone Number Fax Number

I would like the following to be released:

[ ] History & Physical
[ ] Discharge Summary
[ ] Operative Report
[ ] Assessment/Care Plans/Notes
[ ] Test Results
[ ] Emergency Room Record
[ ] Office Notes
[ ] Psychosocial Evaluation
[ ] Psychiatric/Psychological Evaluation
[ ] Other_____

These are the dates of treatment I would like released: _____

I authorize the release of the above information for the purpose(s) of:

[ ] Coordinating/managing my care
[ ] Transferring care to another provider
[ ] My own records/use
[ ] Other: _____

I authorize information to be released by means of: (pick only one)

☐ Paper copy ☐ CD
☐ Secure email to this email address_____
(Note: Please print clearly or we will not be able to email it. Some records may not be able to be emailed and will be mailed.)

By signing this form, I acknowledge that MaineGeneral has privacy and security protections for my information, I understand that there are risks MaineGeneral cannot control. It is possible that my information could be read by a third party. I accept those risks by signing this form and allowing delivery of my records by mail or email.

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I understand that:

- Signing this authorization is not required for receiving treatment, payment, enrollment and eligibility for benefits.
- I can refuse to disclose some or all of the information in my treatment records. If I do so, it could result in an improper diagnosis or treatment, denial of coverage, a claim for health benefits or other insurance or other adverse consequences.
- I can revoke all or part of this authorization at any time by delivering a written, dated and signed Notification. Or I can make an oral statement revoking this authorization to the facility listed above except to the extent that MaineGeneral Health has already acted in reliance on it. I am entitled to a copy of this authorization, upon request.
- Information disclosed through this authorization may be shared again by the recipient and therefore no longer protected by the privacy laws.
- I can cross out any provision on this form with which I disagree.
- Records are kept according to state regulatory guidelines. Some older records may not be available for release because they are beyond these retention periods.
- Maine law allows reasonable fees to be collected for copies of medical records which may not exceed processing costs. MaineGeneral does not charge for copies of records provided for continuing care.

State and federal laws require your specific consent to disclose any of the following types of information (*check the boxes next to the disclosures you wish this authorization to include):*

☐ I authorize the disclosure of information about substance use disorder program treatment. If you authorize the disclosure of such information, the recipient may not redisclose the information unless you give your written consent or such re-disclosure is otherwise permitted by 42 C.F.R. Part 2.

☐ I authorize the disclosure of information pertaining to mental health treatment.
Initial here if you wish to review this information before its disclosure_____

☐ I authorize the disclosure of information pertaining to HIV (Human Immunodeficiency Virus) treatment or testing. If you check this box, please know that persons who have disclosed HIV information have encountered discrimination in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.

This authorization is effective until: _____ (date not to exceed one year). Records created after signature date may require a new authorization form.

_____
Signature of Patient Date

_____
Signature of Authorized Representative Relationship

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