Authorization to Release Health Care Information

Date of Birth of Patient:		Telephone:	
I give permission for	MaineGeneral Medical Cer	nter 🗆 MaineGeneral Community Care	
□ MaineGener	al Medical Center Medical Pr	actice	_
□ MainaGana	ral Repubilitation and Long T	(Name of MaineGeneral Practice)	
	far Kendomtation and Long T	erm Care(Name of Facility)	
□ To give information	to OR \Box To receive	e information from the person/place listed below:	
Name			
Street	City/Town	State Zip Code	
Phone Number		Fax Number	
I would like the follo			
		[] Psychosocial Evaluationm Record[] Psychiatric/Psychological Evaluat	ior
[] Operative Report	[] Office Notes	[] Other	
[] Assessment/Care			
	64 4 4T 11111 1	,	
These are the dates o	f treatment I would like rele	eased:	-
I authorize the releas	e of the above information f	or the purpose(s) of:	
[] Coordinating/mana	aging my care		
[] Transferring care t			
[] My own records/us			
Outer.			

 \Box 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.

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

Signature of Authorized Representative

Relationship





Date