MAINE BEHAVIORAL HEALTHCARE

PATIENT LABEL

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION (PHI)

Patient Name: _____Date of Birth: _____

Address: _____ Phone No (opt).:_____

City: _____ State: _____ Zip Code: _____

FROM -Name Individual/Organization:_____

Address: _____ Phone No (opt).:_____

City: _____ State: _____ Zip Code: _____

The information to be released may be from my electronic health record (EHR) and/or paper medical records. I understand that the data from the EHR are current as of the date printed. I further understand that in reducing the data to paper, information from the electronic database is being reformatted onto paper and the page numbers reflect the printed document, not actual pages in the EHR.

I hereby authorize the above named individual/organization to :☐ Release Records ☐ Speak with ☐Both Release and Speak with
TO -Name Individual/Organization: _____

Address: _____ Phone No (opt).:_____

City: _____ State: _____ Zip Code: _____

Routine Record Sets - Indicate Dates of Service : From: _____ To: _____

☐ Crisis/ED	☐ Hospital Records	☐ Behavioral Health Records	☐ Clinic Records
☐ Diagnostic Tests	☐ Progress Notes	☐ Psychiatric Evaluation	☐ Home Health Records
☐ Consultations	☐ History & Physical	☐ Doctors Notes	☐ Billing Records
☐ Radiology Reports	☐ Discharge Summary	☐ Medication Information	☐ Employee Health Records

☐ Genetic Information/Test Results – specify: _____ ☐ Other- specify: _____

Purpose of Release: ☐ Continuing Care ☐ Transfer of Care ☐ Personal Use/Review ☐ Other-specify:_____

Disclosure Format: *☐ Paper ☐ Flash drive* ***Method*** *☐ Mail* ***Alternate*** *☐ Fax or ☐ Email* ***To****::*_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I DO authorize disclosure of any information relating to **ALCOHOL and/ or DRUG ABUSE**.	I DO NOT: _____ (initial here).
I DO authorize disclosure of any information relating to diagnosis and/or treatment of **Mental Health**.	I DO NOT: _____ (initial here)
I DO NOT want to review Mental Health information prior to being sent.	I want to review:___(initial here)
I DO authorize disclosure of information which refers to **HIV test results, infection status and/or treatment**.	I DO NOT: _____ (initial here)

I understand that:

- I can refuse to disclose some or all of the health care information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.
- I can revoke all or part of this authorization at any time during this time period by communicating my request to the Health Information Management Department, through written or verbal means, and except where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
- I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.
- I understand that I am entitled to a copy of this authorization, upon request.

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

_____ _____
Signature of Patient Date/Time

_____ _____
Signature of Legally Authorized Representative Relationship

_____ _____
Printed Name of Authorized Representative Witness

Information Released

_____

_____

_____

Date Released: _____