AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

2 0 0 4

MaineHealth

Note: All applicable fields must be completed for this form to be considered valid.

Please see your MaineHealth facility's website for instructions and contact information for Health Information Management on where to send the completed authorization.

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Email:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

RELEASE INFORMATION FROM

☐ Franklin Memorial Hospital
☐ LincolnHealth (Miles and St Andrews Campus)
☐ Maine Medical Center
☐ Memorial Hospital (New Hampshire)
☐ Maine Behavioral Health
☐ Pen Bay Medical Center
☐ Stephens Memorial Hospital
☐ Southern Maine Health Care
☐ Waldo County General Hospital
☐ Maine Health Care at Home
☐ Other:_____

RELEASE INFORMATION TO

Name/Facility:_____ Phone:_____

Address:_____ Fax:_____

City:_____ State:_____ Zip Code:_____

☐ Release medical records ☐ Speak to | Discuss ☐ Both

SENSITIVE INFORMATION TO BE RELEASED

I understand that the information to be released may contain sensitive information, and that **unless** I check the relevant line below, I hereby authorize release of the following types of information:

I DO authorize disclosure of any information related to diagnosis and/or treatment of **Mental Health**. ☐ I DO NOT Authorize
☐ I want to review such mental health information before it is sent

I DO authorize disclosure of any information relating to **Alcohol and/or Drug Abuse**. ☐ I DO NOT Authorize

I DO authorize disclosure of information which refers to **HIV Results, Infection Status and/or Treatment**. ☐ I DO NOT Authorize

DISCLOSURE FORMAT *If none selected, paper will automatically be sent*

☐ Paper ☐ Fax (up to 50 pages) ☐ Flash-drive
☐ CD ☐ MyChart

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PURPOSE OF RELEASE* *Why is it needed?*

- ☐ Patient is Moving
- ☐ Legal Purposes
- ☐ Continuing Care
- ☐ Insurance Purposes
- ☐ Disability Determination
- ☐ Transfer of Care (Last 2 years unless specified)
- ☐ Personal
- ☐ Worker's Comp Claim
- ☐ Other:_____

*Please note, a fee may be charged based on the Purpose of the release in accordance with state guidelines

INFORMATION TO BE RELEASED *Check appropriate boxes*

Dates of Service: ☐ **Last 2 Years** **OR** **From:**_____ **To:**_____

- ☐ Hospital Abstract (Discharge Summary, History & Physical, Operative Report, Consults, Labs, Radiology, Cardiology, Emergency)
- ☐ Clinic Abstract (Office Visit Notes, Meds, Labs)
- ☐ Home Health (Plan of Care, Orders, Visit Notes)
- ☐ Immunizations
- ☐ Behavioral Health Records
- ☐ Emergency Department Records
- ☐ Wellness / Rehab
- ☐ Billing
- ☐ Labs Only
- ☐ Radiology Reports
- ☐ Radiology Images (Will be Released on CD)
- ☐ Other:_____
- ☐ Genetic Information and/or Test Results/Pedigree:

Please specify type of information and/or test

SENSITIVE INFORMATION TO BE RELEASED

I understand that 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 is current as of the date printed. I understand that in reducing the data to paper, information from the electronic database is being reformatted onto paper and that the page numbers reflect the printed document, not actual pages in the EHR.
I understand that I can refuse to disclose some or all of the 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 understand that I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, 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 of 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 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, ***unless I notify the HIM Department in writing that no future disclosures should be made***.

Signature:_____ Date: _____

Printed Name of Person Signing (if not patient): _____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney):_____