MaineHealth

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

PATIENT INFORMATION

Name:_____ Date of Birth:_____ Email:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip Code:_____

RELEASE INFORMATION FROM *Indicate the location, provider, or clinics who has the records being requested*

Name of Site(s) Location(s):_____

Provider(s)/Specialty(s):_____ Phone:_____

Address:_____ Fax:_____

City:_____ State:_____ Zip Code:_____

RELEASE INFORMATION TO

☐ **Check here if the records are to be mailed to the patient at the above address, otherwise complete the information below:**

Name/Facility: Phone:

Address:_____ Fax:

City: State: Zip Code:

Email:

☐ Release medical records ☐ Speak to | Discuss ☐ Both

SENSITIVE INFORMATION TO BE RELEASED

Please check YES to indicate <u>if</u> you give permission to release the following information if present in your record.
I understand that the information to be released may contain sensitive information.

☐ Yes ☐ No **Alcohol and/or Drug Use Disorder** treatment information from a federally assisted alcohol or drug use disorder diagnosis or treatment program. (42 CFR Part 2 prohibits unauthorized use or disclosure of these records. Further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2.)

☐ Yes ☐ No **Mental Health Treatment** services provided by a licensed mental health professional.

☐ Yes ☐ No I want to review my mental health treatment information before it is released.
I understand this review must be supervised.

☐ Yes ☐ No **HIV** Test Results, Infection Status and / or Treatment Information.

☐ Yes ☐ No **Genetic Information and/or Test Results**. Please specify the type of information and / or test to be released:
_____

DISCLOSURE FORMAT *Select **one** preferred format; if none selected, paper will automatically be sent*

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

Continue to Page 2

MaineHealth

PATIENT INFORMATION

Name:_____ Date of Birth:_____

PURPOSE OF RELEASE* *Why is it needed?*

- ☐ Continuing Care
- ☐ Transfer of Care (Last 2 years unless specified)
- ☐ Personal
- ☐ Other (Please specify):_____
- ☐ Legal Purposes
- ☐ Disability/Insurance Application/Claim
- ☐ Workers' Comp Claim
- ☐ To support volunteer and employment opportunities as part of the multidisciplinary treatment plan

**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 and **MUST** specify dates*

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

- ☐ 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
- ☐ Notes:_____
  Please specify type or provider
- ☐ Billing
- ☐ Labs Only
- ☐ Radiology Reports
- ☐ Radiology Images (Will be Released on CD)
- ☐ Wellness / Rehab
- ☐ Emergency Department Records
- ☐ Other:_____

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 of the same record set requested 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):_____