Patient Identification

Name:

DOB:

Northern Light Health

- ☐ A.R. Gould Hospital
- ☐ Acadia Hospital
- ☐ Acadia Healthcare
- ☐ Beacon Health
- ☐ Blue Hill Hospital
- ☐ C. A. Dean Hospital
- ☑ Eastern Maine Medical Center
- ☐ Inland Hospital
- ☐ Lakewood
- ☐ Maine Coast Hospital
- ☐ Mercy Hospital
- ☐ Northern Light Home Care & Hospice
- ☐ Northern Light Laboratory
- ☐ Northern Light Medical Transport
- ☐ Northern Light Pharmacy
- ☐ Sebasticook Valley Hospital
- ☐ Work Health

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

	Phone	Fax		Phone	Fax
A.R. Gould Hospital	(207) 768-4175	(207) 768-4060	Lakewood	(207) 873-5125	(207) 861-9967
Acadia Hospital	(207) 973-6100	(207) 973-6822	Maine Coast Hospital	(207) 664-5454	(207) 665-5398
Acadia Healthcare	(207) 973-6100	(207) 973-6822	Mercy Hospital	(207) 879-3373	(207) 822-2469
Beacon Health	(207) 973-5692	(207) 989-1096	Northern Light Home Care & Hospice	(800) 757-3326	(207) 400-8891
Blue Hill Hospital	(207) 374-3458	(207) 374-3971	Northern Light Laboratory	(207) 973-6900	(207) 973-6999
C. A. Dean Hospital	(207) 695-5225	(207) 695-2254	Northern Light Medical Transport	(207) 275-2940	(207) 973-9487
Eastern Maine Medical	(207) 973-7873	(207) 973-7867	Northern Light Pharmacy	(207) 275-3216	(207) 561-4804
Inland Hospital	(207) 861-3150	(207) 861-3158	Sebasticook Valley Hospital	(207) 487-4026	(207) 487-3204

NONDISCRIMINATION STATEMENT: Northern Light Health and its affiliates (Northern Light Health) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language. Northern Light Health does not exclude people or treat them differently because of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language.

Northern Light Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 1-888-986-6341. If you have a TTY, you may also dial 711 Maine Relay.

If you believe that Northern Light Health or any of its affiliates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnicity, age, mental or physical ability or disability, political affiliation, religion, culture, socio-economic status, genetic information, veteran status, sexual orientation, sex, gender, gender identity or expression, or language, you can file a grievance with your Northern Light Health Civil Rights Coordinator, 797 Wilson St., Suite 4, Brewer, ME 04412, 1-866-769-8363 **(telephone),** 1-207-989-1420 **(fax),** or at nondiscrimination@northernlight.org **(email)**. If you need help filing a grievance, your Northern Light Health Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-986-6341 (ATS : 711).
Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-986-6341 (TTY: 711).
Oromo (Cushite): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-986-6341 (TTY: 711).
Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-986-6341（TTY：711）。
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-986-6341 (TTY: 711).
Tagalog (Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-986-6341 (TTY: 711).
Cambodian (Khmer): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ *1-888-986-6341 (TTY: 711)*។

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-986-6341 (телетайп: 711).
Arabic:
(رقم*1-888-986-6341*ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
هاتف الصم والبكم: *711*.)
German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-986-6341 (TTY: 711).
Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-986-6341 (TTY: 711)번으로 전화해 주십시오.
Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-986-6341 (*TTY:* 711).
*Nilotic (Dinka): **PIŋ KENE**: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-888-986-6341 (TTY: 711)*
Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-986-6341（TTY:711）まで、お電話にてご連絡ください。
Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-986-6341 (TTY: 711).

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I authorize the Northern Light Health entity indicated above to release my health information to:

Name (entity or individual)		Phone	
Street	City	State	Zip
Name (entity or individual)		Phone	
Street	City	State	Zip
Name (entity or individual)		Phone	
Street	City	State	Zip
Name (entity or individual)		Phone	
Street	City	State	Zip

NOTE: All disclosures based on this form are limited to records existing at the time the form is signed, unless you (the patient or personal representative) indicate below that you want us to release records related to specific future tests, procedures, appointments, etc.

Indicate the date(s) of service (such as admission date, visit date(s), date range, etc.) (including instructions on release of future records): _____

_____

Specific information/documents to be released or comments/instructions (e.g., the particular practice or department from which to release the records):

_____

_____

PURPOSE: I release the above information for the purpose or purposes of:

☐ On-going treatment/aftercare

☐ Release is to the requesting individual for personal use

☐ Legal proceeding: Name of attorney: _____

☐ Insurance matter: Name of insurance company: _____

This authorization will expire in 12 months unless I give an earlier expiration date here: _____.

NOTE: for purposes of disclosing information which refers to treatment or diagnosis of HIV infection or AIDS, this authorization will not expire and will remain in effect unless revoked.

Your specific consent is required to disclose any of the following types of information ***(check the boxes only if you want this authorization to include this information)***:

☐ I authorize disclosure of federal drug or alcohol abuse program treatment information contained in my medical records. This information may not be re-disclosed by the recipient without my specific written consent.

☐ I authorize disclosure of information derived from behavioral health services provided by a licensed behavioral health professional. The recipient of this information must be specified by name above.

☐ I want to review my behavioral health information before it is released. I understand this review must be supervised (Northern Light Acadia Healthcare or Northern Light Acadia Hospital patients only).

☐ I authorize the disclosure of information which refers to treatment or diagnosis of HIV infection or AIDS. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance and social and family relationships. I understand that this authorization will stay in effect unless I later revoke this authorization. I understand that if I authorize the disclosure of this information to my insurance company, information which refers to treatment or diagnosis of HIV infection or AIDS may be disclosed to my current and future insurance companies, health plans, or payors unless I revoke or update this authorization.

I understand that my treatment is not conditioned on signing this authorization. I will not be denied treatment if I do not sign this form. I may review my record before signing. I may refuse to sign this authorization form. Partial or incomplete information will be labeled as such. I understand that, if I refuse to sign this authorization form, it may result in improper diagnosis or treatment, denial of coverage, denial of a claim for benefits, denial of other insurance or other adverse consequences.

I may revoke this authorization at any time except for the information already disclosed. To revoke my authorization, I will submit a written request to the Medical Records Department of the entity indicated above**.** I understand that, if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage.

I understand that, if this information is disclosed to a third party or to me, the information may no longer be protected by state and federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand that I may have a copy of this authorization form. I decline a copy of this authorization unless I ask for one to be given me.

Signed: _____ Date: _____ Time: _____
(Patient*)

Signed: _____ Relationship: _____ Date: _____ Time: _____
(Authorized Representative*)

*A parent /guardian or other authorized representative is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should sign in addition to their parent/guardian or other authorized representative. If a minor patient consented to his/her own care, the minor patient must sign this authorization form to release records related to that care. Indicate relationship of representative to patient.