Northern Light Health℠

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Information

First Name: _____ **Last Name:** _____ **Middle Initial:** _____ **Date of Birth:** _____

Street: _____ **City/State/Zip:** _____

Check your preferred contact: ☐ **Phone:** _____ ☑ **Email:** _____

Release Information from location(s) check below (who has the records being requested) (REQUIRED):

Please send this completed form to the applicable Health Information Management (HIM) department below.

Northern Light Health Entity			**HIM Phone**	**HIM Fax**
☐ Acadia Healthcare ☐ Acadia Hospital ☐ A.R. Gould Hospital ☐ Blue Hill Hospital	☐ C. A. Dean Hospital ☐ Eastern Maine Medical Center ☐ Inland Hospital ☐ Maine Coast Hospital	☐ Mayo Hospital ☐ Mercy Hospital ☐ Sebasticook Valley Hospital	(207) 973-7873 **Email:** NLHReleaseofInformation@northernlight.org ☐ Any and All Hospitals listed to the left.	(207) 973-7867
☐ Continuing Care Lakewood			(207) 873-5125	(207) 861-9967
☐ Home Care & Hospice			(800) 757-3326	(207) 400-8891
☐ Laboratory			(207) 973-6900	(207) 973-6999
☐ Medical Transport			(207) 275-2940	(207) 973-9487
☐ Pharmacy			(207) 275-3216	(207) 561-4804

☐ Limit information to the specific practice or specialty and include the city of the practice:

_____

Release my health information to the following person/facility, in the format checked below (REQUIRED):

Name/Facility:		Send information via: ☐ Verbal ☐ Secure Email: _____ ☐ Fax: _____ ☐ Postal Mail ☐ Other: _____
Street:	City, State, Zip:	
Name/Facility:		Send information via: ☐ Verbal ☐ Secure Email: _____ ☐ Fax: _____ ☐ Postal Mail ☐ Other: _____
Street:	City, State, Zip:	
Name/Facility:		Send information via: ☐ Verbal ☐ Secure Email: _____ ☐ Fax: _____ ☐ Postal Mail ☐ Other: _____
Street:	City, State, Zip:	

Purpose of Request to Release Information (REQUIRED): Why it is needed….

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

☐ Ongoing Care ☐ Personal Use ☐ Insurance/Disability ☐ Legal Purposes

Date(s) of service (REQUIRED): Specify dates or date range of services: _____.

☐ Future dates of service are authorized upon my request or for ongoing verbal communication until this form expires.

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SCAN TO RELEASE OF INFORMATION NOTE

Form Expiration Date: *This form may be used for future disclosures for up to 1 year from date of signature unless an earlier expiration date is specified:* _____

What Information Can Be Disclosed (REQUIRED)? *Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box.*

☐ **ALL Health Information**	☐ Discharge Summary	☐ Lab Results	☐ Pathology Reports
☐ Abstract Last 3 Years	☐ History/Physical Exam	☐ Medications	☐ Radiology Reports
☐ ED/Walk-In Visit Notes	☐ Immunization	☐ Office Visit Notes	☐ Radiology Images
☐ Consultation Reports	☐ Inpatient Stays	☐ Operation Reports	☐ Therapy Notes

☐ Other: _____

Sensitive Information to be Released (OPTIONAL):

I understand that sensitive information, as described below, will not be released unless I check the relevant boxes below. I hereby authorize release of the following types of sensitive information:

☐ **MENTAL HEALTH**: I DO authorize disclosure of any information related to diagnosis and/or treatment of mental health by a licensed behavioral health professional.
  ☐ I want to review such mental health information before it is sent. For Acadia Hospital or Healthcare, I understand that this review must be supervised.

☐ **SUBSTANCE USE DISORDER TREATMENT:** I DO authorize disclosure of any information related to treatment by a licensed substance use disorders treatment program.
  - *42 CFR part 2 prohibits unauthorized use or disclosure of these records.*

☐ **HIV/AIDS:** I DO authorize disclosure of information related to HIV results, infection status, and/or treatment. 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.

Consent to Authorize Release of Information (REQUIRED):

I understand that signing this form is voluntary and that I have the following rights:

- **Right to Review Before Release**: I understand that I may review my record before signing this form.
- **Right to Decline or Revoke Consent**: I may refuse to sign this form. I may also choose to share some or all the information in my record. Northern Light Health will not deny treatment based on my choice.
  - I understand that restricting or revoking the release of my health information 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 understand that if I consent now, I may withdraw consent later by notifying Northern Light Health in writing. Although, some information may have already been disclosed.

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 if I ask for one to be given me.

The signature of a minor patient is required for the release of some health information.

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

Authorized Representative Printed Name: _____

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 their own care, the minor patient must sign this authorization form to release records related to that care. Indicate relationship of representative to patient.