Northern Light Health

Patient Identification

Acadia Healthcare/Hospital
(207) 973-6100
A.R. Gould Hospital
(207) 973-6822
Beacon Health
(207) 973-5692
Blue Hill Hospital
(207) 989-1096
Home Care & Hospice
(800) 757-3326
C. A. Dean Hospital
(207) 400-8891
Laboratory
(207) 973-6900
Eastern Maine Medical Center
(207) 973-6999
Lakewood
(207) 873-5125
Inland Hospital
(207) 861-9967
Mayo Hospital
(207) 564-4270
Maine Coast Hospital
(207) 564-4360
Medical Transport
(207) 275-2940
Mercy Hospital
(207) 973-9487
Pharmacy
(207) 275-3216
Sebastian Valley Hospital
(207) 561-4804

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 filling a grievance, your Northern Light Civil Rights Coordinator is available to help you.


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）。


Cambodian (Khmer): ឈូរេញឬ ប្រឈាយរីកម្មកម្ពុជិក ការឈុតយើង យើងនឹងឈើស័រថ្មី ជាមួយអ្នកដែលមានភាសាខ្មែរ ដែលចង់ទាញ 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:

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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: ____________________________

I would like my health information provided in the following format:

☐ Secure email: Email address: ...........................................................
☐ Fax: Fax Number: ........................................................................
☐ Mailed to the address above – electronic media (specify CD or thumb drive): ..............................................................
☐ Other (please specify in detail): ......................................................

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, Northern Light Acadia Hospital and Northern Light Mayo 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 their own care, the minor patient must sign this authorization form to release records related to that care. Indicate relationship of representative to patient.