MaineHealth

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

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 *Indicate the location and/or provider/clinic who has the records being requested*

- ○ CHANS Home Health & Hospice
- ○ LincolnHealth (Miles and St Andrews Campus)
- ○ Maine Health Care at Home
- ○ Memorial Hospital (New Hampshire)
- ○ Pen Bay Medical Center
- ○ Spring Harbor Hospital
- ○ Waldo County General Hospital
- ○ Provider/Clinic:______________________________
- ○ Franklin Memorial Hospital
- ○ Maine Behavioral Healthcare
- ○ Maine Medical Center
- ○ Mid Coast Hospital
- ○ Southern Maine Health Care
- ○ Stephens Memorial Hospital
- ○ 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, Substance and/or Drug Use**. ____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
- ○ CD
- ○ Fax (up to 50 pages)
- ○ MyChart
- ○ Flash-drive
- ○ Secure E-mail

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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
- ○ Disability/Insurance Application/Claim
- ○ Legal Purposes
- ○ Worker's Comp Claim
- ○ Other (Please Specify):____

*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
- ○ Notes:_______________________________________
  ____
  Please specify type or provider
- ○ Billing
- ○ Labs Only
- ○ Radiology Reports
- ○ Radiology Images (Will be Released on CD)
- ○ Wellness / Rehab
- ○ Emergency Department Records
- ○ Other:_______________________________________
  ____
- ○ Genetic Information and/or Test Results/Pedigree:
  ____
  Please specify type of information and/or test

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):___________________________