REQUIRED FOR PROCESSING

Name:

Preferred Name:

DOB:

Patient Identification

Northern Light Health

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

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PLEASE FAX FORM TO HIM DEPARTMENT LISTED BELOW

Entity	Phone	Fax
Northern Light Health Hospitals	(207) 973-7873	(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
Work Health	1-844-975-4584	(207) 973-4930

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: _____

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SCAN TO RELEASE OF INFORMATION NOTE

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

☐ Secure email: Email address: _____

☐ Fax: Fax Number: _____

☐ Mailed to the address above; specify electronic media (CD or thumb drive) or paper: _____

☐ 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 and 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*)

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.