Northern Light Health

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

AUTHORIZATION TO OBTAIN HEALTHCARE INFORMATION

Patient Identification

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

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 records related to specific future tests, procedures, appointments, etc., released to Northern Light Health.

Indicate the date(s) of service (such as admission date, visit date(s), date range, etc.) **and specific information/documents to be released** (including instructions on release of future records):

_____

_____

Please send the requested health information to:
Northern Light Health Location Name: _____
Address: _____
Phone:_____
Fax: _____

The purpose of this release is continuing care.
This authorization will expire in 12 months unless I give an earlier expiration date here: _____.

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.

☐ 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 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 institution releasing my records**.** 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 that representative to patient.