6 Glen Cove Drive
Rockport,Maine 04856

Patient Name:
Patient DOB:

PATIENT NAME LABEL

Authorization to Release Protected Healthcare Information

I authorize Pen Bay Medical Center, their authorized employees and agents to:

☐ **Release medical records to:** ☐ **Discuss with:**
☐ **Obtain medical records from:** ☐ **Both release medical records to and discuss with:**

Name _____ Street _____

City or Town _____ State / Zip _____

Fax _____ Phone _____

The following information (specify dates): [unless otherwise noted an abstract will be provided] _____

❑Discharge summary ❑Operative report ❑Inpatient Admission
❑History and physical ❑Test results ❑Progress notes
❑Consultation reports ❑Emergency Room ❑Clinic_____(dates)
❑Day Surgery ❑Medical Records from Other Facilities
❑Other:_____

Information I refuse to disclose: _____

I DO authorize the disclosure of any information relating to the diagnosis or treatment of **ALCOHOL or DRUG ABUSE**. If I authorize the release of this information, I understand that such information cannot be redisclosed by a recipient without my specific consent.	I DO NOT: ____(initial here).
I DO authorize the disclosure of any information relating to the diagnosis or treatment of **MENTAL HEALTH** .	I DO NOT: ____(initial here).
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released.	I DO: ____ (initial here). I understand that such review must be supervised.
I DO authorize disclosure of information which refers to **HIV** test results, infection status or treatment information.	I DO NOT: ____ (initial here).

This disclosure is for the purpose of:_____

I understand that

- I can refuse to disclose some or all of the health care information in my treatment records, but that 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 I will not be denied treatment for refusing to disclose information.
- I can revoke all or part of this authorization at any time during this time period by written notice to the Health Information Management Department except where information has already been acted upon a request for the release of my medical record.
- I can cross out any provision on this form with which I disagree.
- I understand that if information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be redisclosed by the person 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 year from the date of signing. I further authorize future disclosures to the same individual and/or entities during this time period.

_____ _____
Signature of Patient Date

_____ _____
Signature of Legally Authorized Representative Relationship and Date

_____ _____
Printed name of Authorized Representative Witness

Information Released

Pgs _____ Date: _____

Method:

☐ in person ☐ ID verified
☐ FAX ☐ Mail

Staff Initials_____

Pt. Initials: _____