



**P.O. Box 1079 / 195 Union St.
Rockport, ME 04856
Ph. (207) 236-2169
Fx. (207) 230-0413**

Authorization for Release of Health Care Information

I, (patient name) _____ Date of Birth _____

Authorize: Name of Practice _____
Address _____
City _____ State ____ Zip Code _____
Phone _____

To Release/Disclose the specified information noted below to:

Name of Practice _____
Address _____
City _____ State ____ Zip Code _____
Phone _____

My health care records from (date) _____ to (date) _____ or my entire health care record.
(Circle **entire healthcare record** if that is you request)

Purpose of requested disclosure:

At the request of the individual Other: _____
(please specify)

Release only: (write in specific parts of the records: i.e.; lab reports, physician notes for date or dates)

Circle "Yes" if you want the following information released.
Circle "No" if you do NOT want the following information released.

- | | | |
|---|------------|-----------|
| 1. Alcohol or drug dependency, evaluation, diagnosis, or treatment records. | Yes | No |
| 2. Mental health evaluation and treatment records, except psychotherapy notes (I understand that I have the right to review this information under supervision before it is released and I hereby inform you that I do not wish to review that information). | Yes | No |
| 3. HIV/AIDS test results, diagnosis, states, or treatment records. | Yes | No |

I understand that information disclosed under this authorization might be re-disclosed by the recipient, and that any such re-disclosure may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization at any time. I understand I cannot revoke this authorization if **Midcoast Medicine, PA.** has taken action on the authorization. Authorization will be considered inactive when **Midcoast Medicine, PA.** receives a request in writing to revoke authorization.

I understand that I may refuse authorization to release all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences.

This authorization for release is effective for the release of medical information mentioned above to the named recipient only.

This authorization will expire on _____ or upon the following event _____

I understand the signing this authorization is voluntary. My treatment, payment, enrollment in health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

I understand that I have the right to receive a copy of this authorization.

Signature of Patient

Date Signed

Signature of Legal Representative

Date Signed

Check which of the following applies to regarding Legal Representative:

- Legal Guardian
- Executor of Estate
- Health Care Power of Attorney.