Authorization to Release Protected Health Information (PHI)

Name of Patient:______________________________ Date of Birth:________________________

Release of Information From:

Release of Information To
Freeport Medical Center
23 Durham Rd
Freeport ME 04032

Purpose of Release:

- ☐ Transfer of Care
- ☐ Legal Purposes
- ☐ Insurance Claims
- ☐ Worker's Compensation Claim
- ☐ Disability Determination
- ☐ Other:____________________________

Information Released:

- ☐ Entire Record
- ☐ Last (1) Year of Records
- ☐ Last (3) Years of Records
- ☐ Immunization Records
- ☐ Office Notes
- ☐ History & Physical
- ☐ Lab/Pathology Reports
- ☐ Diagnostic Report
- ☐ Consolation Reports
- ☐ Hospital Reports

Sensitive Information To Be Released: I understand the information to be released may contain sensitive information. My specific authorization is necessary to release information pertaining to treatment and/or diagnosis of mental **health** conditions, substance abuse, or HIV/AIDS status. Please check the following authorizations:

☐ Mental Health:	☐ I give consent	☐ I do not give consent
☐ HIV / STD's	☐ I give consent	☐ I do not give consent
☐ Substance Abuse:	☐ I give consent	☐ I do not give consent

Number of Disclosures: This authorization is good for : ☐ A one-time disclosure ☐ Multiple disclosures

This authorization can be revoked at any time except to the extent any person has taken action in reliance upon this authorization. Revocation must be made in writing to the facility releasing the information. Information released pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. A copy of this disclosure is available upon request.

Freeport Medical Center will not condition treatment on the signing of this authorization. I may refuse to sign this authorization. If I refuse to sign this authorization, I recognize that it may result in improper diagnosis, treatment, denial of coverage, denial of claim for benefits, denial of other insurance or other adverse consequences.

This authorization expires 12 months from the date hereof.

I, the undersigned, hereby authorize the release of the protected health information described above subject to the restrictions described above.

Signature:____ Date:_________________________

Printed Name:____

Circle relationship to Patient (if not patient): Parent Legal Guardian Legal Power of Att