12 Stillwater Avenue Suite 1, Bangor, Maine 04401
Phone: (207) 990-1615 **Fax**: (207) 990-5997 **Email:** info@downeastobgyn.com

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AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

RELEASE INFORMATION FROM *Indicate the location and/or provider/clinic who has the records being requested*

Name/Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

RELEASE INFORMATION TO

Name/Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

SENSITIVE INFORMATION TO BE RELEASED

I understand that the information to be released may contain sensitive information and that by checking the box below, I hereby authorize release of the following types of information:

- o I DO authorize disclosure of any information related to diagnosis and/or treatment of **Mental Health**
- o I DO authorize disclosure of any information relating to **Alcohol, Substance and/or Drug Use**
- o I DO authorize disclosure of information which refers to **HIV Results, Infection Status and/or Treatment**

(Maine law requires our practice to inform you that, if this information is misused, disclosing your HIV infection status may have consequences, such as negative treatment in your personal life or by insurance companies. It can be important for providing you needed services & healthcare.)

SPECIFY DATES OF SERVICE

- o All time
- o From (date): _____ to _____

PURPOSE OF RELEASE

- o Continuity of Care
- o Transfer of Care
- o Personal
- o Other (please specify): _____
- o Disability/Insurance Application/Claim
- o Legal Purposes

INFORMATION TO BE RELEASED *check appropriate boxes*

- o Entire Medical Record
- o Labs/Pathology
- o Imaging Reports
- o Operative Reports
- o Office Notes
- o Billing Documents
- o Obstetric Reports
- o Other (please specify): _____

I understand that the information to be released may be from my electronic medical record (EMR). I understand that the data from the EMR is current as of the date printed. I understand that in reducing the data to paper, information from the electronic database is being reformatted onto paper and that the page numbers reflect the printed document, not actual pages in the EMR.

I understand that I can refuse to disclose some or all of the information in my record, but 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 that I can revoke all or part of this authorization at any time during this time period by providing written notice to Downeast Ob/Gyn, except where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits.

I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual 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 (1) year** from the date of signing. I authorize future disclosures to the same individual and/or entity of the same record set requested pursuant to this authorization, **unless I notify Downeast Ob/Gyn in writing that no future disclosures should be made.**

Signature: _____ **Date:** _____

Printed name: _____

Signature of Authorized Representative: _____