Osteopathic **H**ealthcare of **M**aine

Donald V. Hankinson, DO Keelyn Wu, DO Thomas M. Gilson, DO
Jennifer V. Hilton, DO Jeffrey R. Greenfield, DO

98 Clearwater Dr
Falmouth, Maine 04105
Tel (207) 781-7900
Fax (207) 781-2900

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for use or disclosure of protected health information pertaining to:

Name:_____

Address:_____

DOB:_____

Protected health information to be released:

Release my protected health information to: _____

_____

Medical records (specify, can state all): _____

Billing records: (Please specify time frame): _____

***Your specific permission is required to disclose information regarding the following:**
(If not applicable, please check YES)

	Permission	**Initials**
*Treatment by a Mental Health professional or program	**YES NO**	_____
*Drug/Alcohol Abuse	**YES NO**	_____
*HIV Test Results or Status	**YES NO**	_____

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

CONTINUED ON BACK OF FORM

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I understand that I am not required to sign this form and Osteopathic Healthcare of Maine will not condition treatment, payment for services or eligibility for services on whether I sign this form. I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences.

I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.

I understand that I have the right to access or copy the PHI described in this form by making a written request to the Privacy Officer of this practice: Edwinna Parent. A copying fee may be charged as permitted by law.

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Edwinna Parent. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

I understand the PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.

I understand the PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.

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

EXPIRATION: THIS AUTHORIZATION BECOMES EFFECTIVE IMMEDIATELY AND SHALL EXPIRE ON _____. If no date is given, this authorization is valid from 12 MONTHS from signature date.

Signed: _____ Date _____

Print Name: _____

If signed by other than patient, indicate legal relationship: _____