

Osteopathic Healthcare of Maine

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98 Clearwater Drive, Suite One
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Tel (207) 781-7900 Fax (207) 781-2900

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

This authorization is for the 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 with 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 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 based 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 for 12 MONTHS from the signature date.

Signed: _____ **Date** _____

Print Name: _____

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