AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Name of Patient: _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Date of Birth: _____ **Contact Phone:** _____

RELEASE INFORMATION FROM

Name/Facility: _____

Address: _____

_____

Phone/Fax: _____

RELEASE INFORMATION TO

Name/Facility: _____

Address: _____

_____

Phone/Fax: _____

PURPOSE OF RELEASE

☐ Transfer of Care (please state reason) _____

☐ Personal ☐ Legal Purposes ☐ Payment of Insurance Claims ☐ Medical

☐ Application for Insurance ☐ Disability Determination ☐ Workers' Comp Claim ☐ Other_____

Dates of Service: From _____ To _____

SPECIFIC INFORMATION TO BE RELEASED

☐ Last one (1) Year of Records ☐ Last three (3) Years of Records ☐ Last five (5) Years of Records

☐ Entire Medical Record ☐ History and Physical ☐ Diagnostic Reports

☐ Office Visit Notes ☐ Lab/Pathology Reports ☐ Consultation Reports

☐ PT / OT Notes ☐ Radiology/MRI Reports ☐ Hospital Reports

☐ Admission & Discharge Summary ☐ Operative Report ☐ Other Specific Records_____

I **DO** authorize the disclosure of any information relating to the diagnosis or treatment of **Alcohol** or **Drug Abuse**. If I authorize the release of this information, I understand that such information cannot be redisclosed by a recipient without my specific consent.	I DO NOT: _____(initial here)
I DO authorize the disclosure of any information relating to the diagnosis or treatment of **MENTAL HEALTH.**	I DO NOT: _____(initial here)
If I authorize the release of Mental Health, I DO NOT want to review the information before it is released. I understand that such review must be supervised.	I DO: _____(initial here)
I DO authorize disclosure of information which refers to HIV test results, infection status or treatment information.	I DO NOT: _____(initial here)

NUMBER OF DISCLOSURES

This authorization is for ☐ **A one-time** disclosure **OR** ☐ **Multiple** disclosures

- This authorization may be revoked at any time except to the extent any person has taken action in reliance upon this authorization. Further details on revocation of this authorization are included in the AtlanticProCare's notice of privacy practices.

- This authorization **expires 12 months** from the date hereof unless an earlier date or event is stated here:
  I, the undersigned, hereby authorize the release of the protected health information described above subject to the restrictions described above:

Signature: _____ Date: _____

Printed Name of Person Signing (if not patient):_____

Relationship to Patient (if not patient):_____

☐ Parent ☐ Legal Guardian/Conservator ☐ Health Care Power of Attorney

1274 Congress St, Portland, ME 04102 (207) 774-1002 www.atlanticprocare.com

Information Released

Date:_____

Pages_____

☐ In Person

☐ ID Verified

☐ Fax

☐ Mail

Staff Initials:_____

Patient Initials:_____

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