



## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

**Patient Name (Please Print):** \_\_\_\_\_ **DOB:** \_\_\_\_\_

As specified below, I hereby authorize Maine Osteopathic Health and its authorized employees and agents to:

☐ **Release medical records to** (Patient; legal guardian, medical provider):

☐ **Obtain medical records from** (Medical provider):

Organization/Clinic Name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

**The specific information I want disclosed includes:**

☐ All health information pertaining to (Specify body part): \_\_\_\_\_

**OR** only release indicated records pertaining to (Specify body part): \_\_\_\_\_

☐ Office visit notes ☐ Laboratory reports ☐ Operative reports ☐ Therapy notes ☐ EMG report

☐ Imaging/Radiology reports ☐ Other (Please specify): \_\_\_\_\_

Dates of Service (Example – last 3 years): \_\_\_\_\_

This disclosure is for the purpose of: \_\_\_\_\_

My specific permission is required to disclose information regarding HIV test results or status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment. Check one of the options below and initial at end to confirm your choice:

☐ **I DO** authorize disclosure of information which refers to HIV test results, infection status or treatment information.

Initials: \_\_\_\_\_

☐ **I DO NOT** authorize disclosure of information which refers to HIV test results, infection status or treatment information. Initials: \_\_\_\_\_

**I understand that:** I am not required to sign this form and that I may refuse to disclose all or some of the above healthcare information in my treatment records, but that refusal may result in improper diagnosis or treatment, denial of coverage for a claim for health benefits, denial of other insurance, or other adverse consequences. PHI released pursuant to this authorization may include records generated by another healthcare provider or facility. I further understand that I may 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. PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by confidentiality laws. I am entitled to a copy of this authorization, upon request.

**EXPIRATION:** This authorization becomes effective immediately and shall expire one year from the date of signing.

**SIGNED (patient or his/her legally appointed representative):**

\_\_\_\_\_  
**Date:** \_\_\_\_\_

**Completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_