Medical Records requested	
Permission to share	

Office Use Only	
Date Rec'd	
Approved by	
Rec'd by MedRec	
Date Processed	
Faxed Mailed	
Other	

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

Patient's Name:			Date of Birth:
Name Used When Treatment O	ccurred (if different from a	above):	
give permission to (Name of He	ealth Center)		
\square To give my healthcare in	formation to:	□ То	get my healthcare information from:
Name:			
Street Address:			
City:	State	:	Zip Code:
Telephone Number:		Fa	x Number:
Reason for request (please spec	ify):		
_	ds can be given to or prov	ided by ind	ividual or organization named above.
Check all that apply:	Office Visit Net	0.0	☐ HRCHC Behavioral Health
☐ Consultant Reports	☐ Office Visit Note		
☐ Hospital Notes	☐ Operative Repo		
☐ Imaging Report	☐ Other, please sp	эесіту:	
☐ Laboratory Results			
give permission to the provide	er to give or get the follow	ing kinds o	f information by checking the boxes
pelow (check ONLY those items	s you want to be released):	
	•		ems you want to be released.
			rmation related to the diagnosis or are potential risks associated with the
			crimination and changes in family and
social relationships.			
	•		at 42 C.F.R. Part 2. This includes such
			ther substance use/recovery information provider or other providers (e.g., BHC
		' = '	ograms" under 42 C.F.R. Part 2) may not be
	2 and may be disclosed ev		• •
Mental health informat	ion created or maintained	l by licensed	d mental health facilities and private
counselors are subject t	o Maine's Rights of Recipie	ents of Mer	ntal Health Services law and require your

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 I can withdraw my consent at any time by completing a revocation form available at the Health Ce However, anyone who has used information given or received under the original permission cann held to be in violation of my right to the confidentiality of my medical information. A decision to we my consent to provide records, however, may result in the denial of health benefits or insurance or benefits or other adverse events. I can refuse to disclose some or all of my records. But if I do so, it could result in an improper diag treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences. Partial or incomplete records will be labeled as such to inform the provider receiv of their status. The Health Center may not withhold treatment whether or not I provide this perm form. I am entitled to a copy of this permission form. The Health Center cannot be held responsible if the person or organization to whom records and information have been given gives those records and information to someone else. I permit the provider to use this form to make additional disclosures of information permitted by this 	ot be withdraw
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I permit the provider to use this form to make additional disclosures of information permitted by this	
	form.
This form will expire one year from the date signed unless I revoke my permission sooner, or provide expiration date here	an earlie
Signed: Date Representative Date Related	tionship
Please Print Name:Phone #:	•

For Behavioral Health Records

2 01/04/2022