

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Belgrade Regional Health
 4 Clement Way
 Belgrade, ME 04917-4370
 Fax: 207-495-3353

Bethel Family Health Center
 32 Railroad St | PO Box 1367
 Bethel, ME 04217-1367
 Fax: 207-824-0012

Bingham Area Health & Dental Center
 237 Main St | PO Box 746
 Bingham, ME 04920-0746
 Health Fax: 207-572-3641
 Dental Fax: 207-672-4829

Bulldog Health Center
 Lawrence High School
 9 School St
 Fairfield, ME 04920-0746
 Fax: 207-861-9625

Lovejoy Health Center
 7 School St, Suite 1
 Albion, ME 04910-6501
 Fax: 207-861-9624

Madison Area Health Center
 8 South Main St
 Madison, ME 04950-4501
 Fax: 207-696-3974

Mt. Abram Regional Health Center
 25 Depot St
 Kingfield, ME 04947-4208
 Fax: 207-265-5004

Rangeley Family Medicine
 42 Dallas Hill Rd | PO Box 569
 Rangeley, ME 04970-0569
 Fax: 207-864-2969

Richmond Area Health
 24 Gardiner St
 Richmond, ME 04357-1336
 Fax: 207-737-4412

Sheepscot Valley Health Center
 47 Main St | PO Box 207
 Coopers Mills, ME 04341
 Fax: 207-549-3439

Strong Area Health & Dental Center
 177 North Main St
 Strong, ME 04983-3005
 Health Fax: 207-684-3368
 Dental Fax: 207-684-3049

Tiger Health Center
 Gardiner Area High School
 40 W Hill Rd
 Gardiner, ME 04345
 Fax: 207-861-9630

Western Maine Family Health Center
 16 Depot St, Suite 300
 Livermore Falls, ME 04254-1311
 Fax: 207-897-2321

Name: _____ **DOB:** _____

Name used when treatment occurred (if different from above): _____

Use this form to give permission to HRCHC to share or receive your medical records and information containing protected health information with or from the entity or person listed below.

I give permission to HRCHC:

☐ To **GIVE** my healthcare information to:

☐ To **GET** my healthcare information from:

Person's Name or Entity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Purpose of Release (check all that apply):

☐ Personal Use ☐ Legal Purposes ☐ Transfer of Care ☐ Other: _____

Identify what medical records and information should be included in the protected health information:

☐ Office visit notes ☐ Laboratory/Pathology Results ☐ Imaging Results ☐ Hospital Documents
☐ Consultant reports ☐ HRCHC Behavioral Health Records ☐ Immunizations ☐ Diagnostic
☐ Entire Medical Record ☐ Dental Records: Notes and Imaging ☐ Other: _____

Records for these dates: From: To:

***HRCHC will release physical or digital medical records for the last 3 years unless other dates are specified above.**

☐ **If HRCHC is disclosing your records: Check Here if you want to review the records before they are released. Please make an appointment to view the records in our Office before the records are released.**

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name: _____ DOB: _____

If I have been diagnosed or treated for any of the following, I understand that the disclosing entity needs my specific consent. Indicate whether you DO or DO NOT authorize the release of protected health information for each of the following by initialing the appropriate box.

I DO	I DO NOT	Authorize the release of PHI regarding treatment for SUBSTANCE USE DISORDER PROGRAM RECORDS AND INFORMATION PROTECTED BY 42 C.F.R PART 2.
initials	initials	
I DO	I DO NOT	Authorize the release of PHI regarding treatment outside of HRCHC for MENTAL HEALTH AND BEHAVIORAL HEALTH . I understand that I have the right to review any medical records containing PHI related to my mental and behavioral health that is maintained by licensed mental health facilities or agencies at any reasonable time before deciding to authorize the disclosure on this form.
initials	initials	
I DO	I DO NOT	Authorize the disclosure of HIV/AIDS INFORMATION, INCLUDING test results. I understand that there are potential risks associated with the disclosure of HIV/AIDS information including but not limited to discrimination and changes in family and social relationships.
initials	initials	

I understand that:

- I can withdraw my consent at any time by completing a revocation form available at one of our health centers, subject to the right of any person who acted in reliance of this authorization before receiving notice that it was revoked.
- I can refuse to disclose some or all my records. But if I do so, it could result in an improper diagnosis or 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 receiving them of their status. The health center will not withhold treatment whether I provide this permission form or withdraw my consent to disclose Protected Health Information except as authorized by law.
- I am entitled to a copy of this authorization form.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I permit HRCHC 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 an earlier expiration date. If you would like to provide an expiration date, please inform your health center.

I, the undersigned, hereby authorize the disclosing entity and its designated employees or agents to release/obtain/discuss medical information from my health record.

Signature of Patient/Authorized Representative

Date

Legal Authority
**Describe your legal authority to act on behalf of the patient (e.g., Guardian, Power of Attorney agent). We may require documentation of your authority.*

Please Print Name: _____

Phone #: _____

*** Signature by an authorized representative certifies to the disclosing entity that such person has the legal authority indicated to authorize disclosure of the patient's information and records on behalf of the patient.

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: This record which has been disclosed to you is protected by Federal confidentiality rules (42 CFR part 2). These rules prohibit you from using or disclosing this record, or testimony that describes the information contained in this record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against the patient, unless authorized by the consent of the patient, except as provided at 42 CFR 2.12(c)(5) or as authorized by a court in accordance with 42 CFR 2.64 or 2.65. In addition, the Federal rules prohibit you from making any other use or disclosure of this record unless at least one of the following applies: (i) further use or disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or as otherwise permitted by 42 CFR part 2; (ii) you are a covered entity or business associate and have received the record for treatment, payment, or health care operations; or (iii) you have received the record from a covered entity or business associate as permitted by 45 CFR part 164, subparts A and E. A general authorization for the release of medical or other information is NOT sufficient to meet the required elements of written consent to further use or redisclose the record (see 42 CFR 2.31).