HEALTHREACH
COMMUNITY HEALTH CENTERS

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: 207-672-3641
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.**

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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).