GREATER PORTLAND HEALTH

CARING FOR THE WHOLE COMMUNITY

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

180 Park Avenue, Portland, Maine 04102

Phone: (207) 874-2141 Fax: (207) 874-0101

NOTE: Please note that all applicable fields must be completed for this form to be considered valid and to be processed.

1. General Release: **Patient Full Name**: _____ **Date of Birth:** _____, pursuant to 22 M.R.S.A. 1711-C (3), hereby authorizes Greater Portland Health, employees and agents, to:

(check box that applies)

☐ **obtain records from:** ☐ **release records to:**

OR

☐ **speak to/discuss with:** ☐ **speak to/discuss with:**

Name: _____ Phone: _____

Mailing address: _____ Fax: _____

2. Purpose of Release: The specific purpose(s) of disclosure of this information:
(Obtaining records):

☐ Personal use/review ☐ Assist in treatment ☐ Program eligibility ☐ Legal Purposes
☐ Referral/Aftercare services ☐ Copy of medical records ☐ Transfer of Care ☐ Other:_____

This release covers the specific information listed below in my integrated health records, as indicated in Section 3 below. Specific information to be released - check all that apply:

☐ ONE YEAR of full medical records ☐ FIVE YEARS of full medical records
☐ Current Immunization record ☐ Last Pap smear
☐ Last Mammogram ☐ Labs/Pathology
☐ Last Colonoscopy ☐ Radiology reports
☐ Mental Health Assessment as Applicable, Behavioral Health, Substance Abuse Assessment as applicable.
☐ All medical records in the chart
☐ Other specific medical records: _____

3. Information to be released (check all that apply):

☐ **I DO** / ☐ **I DO NOT** specifically authorize the release of Substance Use records. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Federal HIPAA privacy regulations, 45 C.F.R. pts 160 and 164, and cannot be disclosed without my written permission unless otherwise provided for by laws. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at

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Patient Full Name: _____ Date of Birth: _____

§§2.12(c)(5) and 2.65.

☐ **I DO** / ☐ **I DO NOT** specifically authorize the release of Mental Health records. I understand that this information is protected by State confidentiality laws (34 M.R.S.A. 1207; Rights of Recipients of Mental Health Services) and the Federal HIPAA privacy regulations, 45 C.F.R. pts 160 and 164, and cannot be disclosed any further without my written permission unless otherwise provided by laws. I understand that I may revoke this authorization at any time, orally or in writing, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation.

☐ **I DO** / ☐ **I DO NOT** specifically authorize the release of information relating to HIV/AIDS.

☐ **I DO** / ☐ **I DO NOT** specifically authorize the release of information relating to sexually transmitted diseases.

☐ **I DO NOT** / ☐ **I DO** want to review the information before it is released. The recipient should not re-disclose this information without my written permission.

4. **Subsequent Release**: ☐ **I DO** / ☐ **I DO NOT** authorize release of health care information that is obtained by Greater Portland Health after the date of release.

5. **Disclosure format of medical records (please select one). *Fees may apply*:**
   ☐ Mail ☐ Fax (up to 50 pages)
   ☐ CD mailed to you ☐ Other:

6. **I Understand That**:
   (1) Greater Portland Health cannot withhold treatment if I refuse to sign this Authorization, unless it relates to research-related treatment or treatment provided solely to create and disclose health information to a third party; (2) I may review my records prior to release and refuse to disclose some or all of them; (3) I may revoke all or part of this Authorization at any time by notifying Greater Portland Health; (4) In some cases a refusal or revocation may result in improper diagnosis or treatment, denial of insurance coverage or other similar consequences; (5) A disclosure of information carries with it the potential for re-disclosure if the recipient is not subject to the state or federal confidentiality rules described above; and (6) I may have a copy of this Authorization.

   This Authorization will become effective when I sign and date it, and will remain effective for twelve (12) months or until the expiration date entered below, whichever is sooner. I acknowledge that I am at least 18 years of age or an emancipated minor.

_____ _____ _____

Signature of: ☐ Patient ☐ Parent / Legal Guardian Date Authorized Expiration Date

Patient printed name: _____