northern maine MEDICAL CENTER
194 East Main Street | Fort Kent, ME 04743 | (207) 834-3155 | nmmc.org

AUTHORIZATION TO OBTAIN AND/OR RELEASE HEALTHCARE INFORMATION

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____ **Patient Phone:** _____

I hereby authorize Northern Maine Medical Center to Obtain and/or Release my health information as described herein.

This information includes:

☐ All of my medical record information, including history, dates, course and summary of treatment.
☐ Statements I have added to my medical records, with responses if any.
☐ Lab tests of _____ ☐ Clinic Reports of _____
☐ X-ray(s) of _____ ☐ EKG(s) of _____
☐ Surgical Reports of _____ ☐ ER Report of _____
☐ Ongoing verbal/written communication for treatment and discharge planning
☐ Other _____

Release Information to or Obtain Information from:

(Name of Individual or Facility): _____

Address: _____

Phone #: _____ Fax: _____ Email: _____

This information may be used for:

☐ Ongoing Treatment/Aftercare ☐ Verification of Services

☐ Insurance Purposes ☐ Other _____

I DO ☐ DO NOT ☐ authorize the receipt and/or disclosure of any information relating to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent. To the extent that my record contains information regarding alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I authorize disclosure of such information.

I DO ☐ DO NOT ☐ authorize the receipt and/or disclosure of any information relating to the diagnosis or treatment of MENTAL HEALTH under this authorization. If I authorize the release of this information **I DO ☐ DO NOT ☐** want to review this information before it is released. I understand that any such review may be supervised.

I DO ☐ DO NOT ☐ authorize the receipt and/or disclosure of any information relating to the diagnosis or treatment of an HIV infection under this authorization

I DO ☐ DO NOT ☐ give permission to my immediate family member _____ to view my current record as part of their job duties as an employee of NMMC. Only records needed to perform their job duties to care for me will be reviewed. Depending on staffing NMMC will strive to accommodate this request (immediate family members are parents, spouses, significant other, siblings and children).

My consent to release these records is effective for up to **one year** from the date shown below, unless I specify a different expiration date here: _____. I authorize future disclosures regarding these records to the same individuals or entities during this time period.

I understand that:

- I may revoke all or part of this authorization by notifying the facility or entity where the records were requested from in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.
- I may refuse to disclose all or some of the information in my medical records.
- A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I may have a copy of this form upon request.
- I may cross out any words on this form with which I disagree.
- Any healthcare information released may be transmitted by fax according to Northern Maine Medical Center's Policies.

Patient Signature: _____ Date Signed: _____ Time: _____

Parent, Legal Guardian or Authorized Representative: _____ Relationship to Patient: _____

Witness: _____