PATIENT PORTAL REPRESENTATIVE REQUEST/AUTHORIZATION

194 East Main Street
Fort Kent, ME 04743

AUTHORIZATION TO OBTAIN AND/OR RELEASE HEALTHCARE INFORMATION

Check (x) appropriate box(es): ☐ Release To ☐ Obtain From

I, _____, authorize NORTHERN MAINE MEDICAL CENTER to disclose and discuss my medical
(Patient)

records with _____.
(Name of person assigned as your patient portal representative)

This information includes:

☒All of my medical record information, including history, dates, course and summary of treatment.
☒Patient Portal

This information may be used for:

☒Ongoing Treatment/Aftercare/Patient Portal

I DO ☐ DO NOT ☐ authorize the release 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 medical 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 release 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 release of any information relating to the diagnosis or treatment of an HIV infection under this authorization.

My consent to release these records is effective until _____ (for up to one year from today's date), and 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 at any time 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.
- 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 Information:

Patient Signature: _____ Date: _____ Time: _____ Witness: _____

Patient Date of Birth: _____ Patient Phone Number: _____

Patient Email Address: _____

Assigned Representative Information:

Assigned Representative Signature: _____ Date: _____

Representative Date of Birth: _____ Representative Phone Number: _____

Representative Email Address: _____