MID COAST–PARKVIEW HEALTH
123 Medical Center Drive, Brunswick, Maine 04011
(207) 373-6000 www.midcoasthealth.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

FROM: (Name & Address of Medical Facility)

TO: (Name & Address of Medical Facility/Person(s))

PATIENT NAME used when treatment occurred:_____

DATE OF BIRTH: _____/_____/_____ CURRENT ADDRESS: _____

_____

PHONE NUMBER: _____ _____

SPECIFY INFORMATION TO BE DISCLOSED:

☐ Entire Record ☐ Operative Report ☐ Pathology Report(s)
☐ Hospitalization Record ☐ Radiology Report ☐ Photographic Images
☐ Physicians' Orders ☐ Diagnostic Test ☐ Other:_____
☐ Laboratory Reports ☐ Emergency Record _____

DATES OF TREATMENT:_____

MY HIGHLY CONFIDENTIAL INFORMATION:

☐ I do ☐ I do not : authorize the release of records pertaining to Mental Health
☐ I do ☐ I do not : authorize the release of records pertaining to HIV/AIDS
☐ I do ☐ I do not : authorize the release of records pertaining to Substance Abuse
☐ I do ☐ I do not : authorize the release of records pertaining to Domestic Violence or Sexual Assault
☐ I do ☐ I do not : authorize the release of records pertaining to Genetic Testing Results

I understand that authorization to release this highly confidential information requires my signature each time.

THE PURPOSE OF THIS RELEASE IS TO:

☐ transfer my care ☐ process my claim ☐ other:_____
☐ allow you to discuss my health care with:_____

I understand that Mid Coast–Parkview Health cannot guarantee that my protected health information will not be released to a third party.

I know that I may refuse to sign or may take back this authorization at any time, for any reason and that doing so will not affect the start, continuation or quality of my care at Mid Coast–Parkview Health. However, if my care at Mid Coast–Parkview Health is for the sole purpose of creating health information for release to the receiver listed above, Mid Coast–Parkview Health may refuse to treat me if I do not sign this authorization form. I know that refusing to sign or taking back this authorization may result in wrong diagnosis or treatment, denial of coverage or payment of claims by my insurance company or other poor outcomes. This authorization will remain in effect for one year unless I request in writing that it be removed before then. I may request a copy of this authorization form.

Transmit electronically (by alternate devices) ☐ YES ☐ NO

_____ _____
Signature of **Patient** Date/Time

_____
Patient Name Printed

_____ _____
Signature of Legally **Authorized Representative** **State the relationship**