Patient Name:

Date of Birth:

☐ AFFILIATED LABORATORY, INC.
417 STATE STREET
BANGOR, MAINE 04401
☐Portland
☐Rutland, VT
☐Union Street

☐ EASTERN MAINE MEDICAL CENTER
489 STATE STREET
BANGOR, MAINE 04401

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Identification

I authorize the EMHS entity indicated above to release my health information to:

Name (entity or individual)			Phone
Street	City	State	Zip
Name (entity or individual)			Phone
Street	City	State	Zip
Name (entity or individual)			Phone
Street	City	State	Zip
Name (entity or individual)			Phone
Street	City	State	Zip

Indicate the date(s) of service (such as admission date, visit date(s), date range etc.):

_____

Specific information to be released or comments/instructions:

_____

_____

PURPOSE: I release the above information for the purpose or purposes of:

[ ] On-going treatment/aftercare

[ ] Release is to the requesting individual for personal use

[ ] Legal proceeding: Name of attorney: _____

[ ] Insurance matter: Name of insurance company: _____

Unless I revoke this authorization, it will expire in 12 months or upon the following date if sooner: _____.
NOTE: for purposes of disclosing information which refers to treatment or diagnosis of HIV infection or AIDS, this authorization will not expire.

Your specific consent is required to disclose any of the following types of information ***(check the boxes only if you want this authorization to include this information)***:

☐ I authorize disclosure of federal drug or alcohol abuse program treatment information contained in my medical records. This information may not be re-disclosed by the recipient without my specific written consent.

☐ I authorize disclosure of information derived from mental health services provided by a licensed mental health professional. The recipient of this information must be specified by name above.

☐ I want to review this information before it is released. I understand this review must be supervised. *(See back of page for a supervised review.)*

☐ I authorize the disclosure of information which refers to treatment or diagnosis of HIV infection or AIDS. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance and social and family relationships. I understand that this authorization will stay in effect unless I later revoke this authorization. I understand that if I authorize the disclosure of this information to my insurance company, information which refers to treatment or diagnosis of HIV infection or AIDS may be disclosed to my current and future insurance companies, health plans, or payors unless I revoke or update this authorization.

I understand that my treatment is not conditioned on signing this authorization. I will not be denied treatment if I do not sign this form. I may review my record before signing. I may refuse to sign this authorization form. Partial or incomplete information will be labeled as such. I understand that, if I refuse to sign this authorization form, it may result in improper diagnosis or treatment, denial of coverage, denial of a claim for benefits, denial of other insurance or other adverse consequences.

I may revoke this authorization at any time except for the information already disclosed. To revoke my authorization, I will submit a written request to the Medical Records Department of the entity indicated above**.** I understand that, if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage.

I understand that, if this information is disclosed to a third party or to me, the information may no longer be protected by state and federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand that this authorization applies to records created on or before the date indicated below unless related to this visit, a series of visits, or admission.

I understand that I may have a copy of this authorization form. I decline a copy of this authorization unless I ask for one to be given me.

Signed: _____ Date: _____ Time: _____
(Patient*)

Signed: _____ Relationship: _____ Date: _____ Time: _____
(Patient Representative)

*A parent or guardian is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should also sign. If an adult is unable to make or communicate medical decisions, then the following may sign in the priority given: agent under healthcare power of attorney, guardian, spouse, next-of-kin. Indicate capacity of representative.

For Clinical Use Only **Supervised Review of Mental Health Treatment Records**

Any review of mental health treatment records by the patient must be supervised by the treating clinician or designee and documented below:

1. Date of Review: _____
2. Name of Person Supervising the Review: _____
3. This review:
   ☐ Is routine ☐ Involves reasonable concern of possible harmful effect to the patient
4. In cases where access of the guardian to the record would create documented imminent danger to the patient, was access to all or part of the record denied to the patient or the guardian?
   ☐ Yes ☐ No
5. If access was denied, explain the reason for the denial and indicate the portion of the record subject to the denial:
   _____
   _____

Signature of Reviewer: _____
Date/Time: _____