Navigating Wellness Primary Care
50 Columbia Street #11, Suite 62
Bangor, ME - 04401-6331

2024 Release of Information

Client Name _____

Client Date of Birth _____

Authorization to Release Information

This form, when completed and signed by you, authorizes me to release and/or obtain protected health information from your clinical record to and/or from the person you designate.

I authorize Linette Mauya PMHNP to (check all that apply):

- ☐ Release protected information to /
- ☐ Exchange protected information with
- ☐ My PCP
- ☐ My therapist
- ☐ My patient advocate

Records can be faxed to: Name : Tel:

Name of Provider releasing information or exchanging information: _____

Phone Number _____

Address, city, state and zip code

Information to be disclosed/exchanged (check all that apply): *

- ☐ Diagnosis/Assessment & Treatment Recommendations
- ☐ Labs
- ☐ Psychiatric Evaluation and Medication notes
- ☐ Treatment Notes
- ☐ Discharge Summary and Recommendations

Please specify if you want to release records from: *

- ☐ All dates
- ☐ A specific date range

If a specific date range, please specify (dd/mm/yyyy to dd/mm/yyyy): _____

The purpose of such disclosure is: *

- ☐ To facilitate continuity of care and treatment planning

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I understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to Linette Mauya , PMHNP , ARNP except to the extent that action has already been taken to release this information. This Authorization shall remain valid unless revoked but will expire in 1 year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. Linette Mauya , PMHNP , ARNP will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

Patient Signature (if age 13+) _____

Parent/Guardian Signature (if applicable) _____

Date of Signature * _____

Redisclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Linette Mauya , PMHNP , ARNP cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.