Anchored Women's Health, LLC
710 Bucksport Road Ellsworth, ME 04605
207-573-0270
601-429-9178
www.anchoredwomenshealth.com

Authorization for Release of Medical Information

Patient Name: _____Date of Birth: _____

Maiden Name/Other Names: _____

Phone Number: _____

I hereby authorize Anchored Women's Health, LLC to:
_____Release Information to: **OR** _____ Obtain Information From:

Person / Agency: _____

Address: _____

City, State, Zip: _____

Phone # _____ Fax #_____

IMPORTANT: DATES OF TREATMENT PLEASE

Purpose of Information Requested:	**Dates of Treatment Requested:**
_____Second Opinion _____Continued Treatment _____Personal Use _____Legal Use _____Employment _____Other (please specify) _____	**Information Requested:** *(Please Circle Y or N for each item)* Verbal Information Y N Lab Reports Y N Progress Notes Y N Radiology Reports Y N Other (please specify) _____ Dates of Treatment from:_____to:_____

I understand that my medical record may include sensitive information including but not limited to the diagnosis and treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), HIV status and/or STD's. I understand and agree that the information, if any pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL THE STATEMENT THAT APPLIES: ***(you must initial one)***

I Do_____ I Do Not_____ Authorize this information to be released.

Release Limitations, if any: _____

The above information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The general authorization for the released of medical information and other information is not sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

* I may refuse to sign this authorization form. Anchored Women's Health, LLC will not condition or deny treatment on my signing this authorization.

DURATION	This consent will expire **one (1) year from the date of signature** unless otherwise specified. I also understand that this authorization can be revoked in writing at any time except to the extent that action has been taken in reliance of this authorization.
REVOCATION	I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on this signed authorization by notifying Anchored Women's Health, LLC in writing or by filing out a Revocation of Authorization Form
REDISCLOSURE	When your medical information is released pursuant to a valid authorization you should be aware of the following: That the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.

***TREATMENT MAY NOT be withheld or conditioned on obtaining authorization*.**

_____ _____
Signature of Patient/ or Legal Representative Date

_____ _____
Relationship to Patient Date

_____
Expiration Date
(1-Year from above date)