AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name:		Date of Birth:	
Patient's Address:		Date of Request:	
Home Phone:		Cell Phone:	
Email:			

Authorized Representative* making request (if other than the patient): _____

*Authority of Authorized Representative:

- O Guardian
- O Health Care Power of Attorney
- O Health Care Surrogate
- O Parent of Minor Patient
- O Personal Representative of Deceased Patient's Estate
- O Other:

I Hereby Authorize: _____

(Name of Individual or Previous Provider &/or Practice Name)

(Please provide address and contact information for Individual or previous provider:)

Address: _____ Phone: _____ Fax: _____

_____

Release Information To: _____

(Please pick one)

- O Mail: _____

  _____
- O Fax: _____
- O Hold for pick up
- O Discuss my health information in person

INFORMATION TO BE RELEASED (check all that apply):

- O My complete medical record
- O Discharge Summary
- O Lab tests
- O Practitioner Office Records
- O History and Physical Exams
- O Emergency Room Records
- O Operative Records/Consults
- O X-Ray Reports/Films
- O My medical records from the dates ____/____/____ to ____/____/____
- O Other (please specify):

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

I specifically intend this authorization to include the disclose of (**initial all that apply**):

[___] **Mental and behavioral health records and information maintained by licensed mental health treatment facilities or agencies, or related to mental health services provided by license mental health professionals.**
I understand I have the right to review my mental and behavioral health records at any reasonable time before deciding to authorize their disclose on this form.

[___] **Substance abuse program record and information**

[___] **HIV (Human immunodeficiency virus) record and information**
Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.

I intent this authorization to include the disclosure of records and information the disclosing facility or provider has received from other healthcare providers or facilities. I authorize that subsequent disclosures of information within the scope of this authorization may be made pursuant to this same authorization.

I authorize the disclosure of the above information for the following purpose(s):

O At my request	O Treatment, coordination or continuity of care	O Insurance coverage or payment for care and services	O Legal matter or proceeding
O Consent to Share	O Other: (specify)		

This authorization shall expire one (1) year from the date of my signature below, unless earlier revoked by me or I enter an alternative expiration date here: _____

By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of the above healthcare information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying Village Family Healthcare, LLC. in the manner described in Village Family Health Care, LLC's Notice of Privacy Practices (except to the extent that any person has already acted in reliance on it), but that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- Village Family Health Care, LLC. will not condition services or treatment based on whether I sign this authorization. There is the potential that information disclosed pursuant to this authorization may be re-disclosed by persons or entities receiving the information that, as a result, the information may no longer be protected.
- A fee for the cost of processing this request may be charged.
- I have the right to a copy of the signed authorization.

Patient's Signature: _____ Date: _____
*Or Authorized Representative