PINES
HEALTH SERVICES

P.O. Box 40, Caribou, ME 04736

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Printed Name: _____ Date of Birth: _____ Email: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Note: All applicable fields must be completed for this form to be considered valid

Release Information To:

Name/Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Email: _____

☐ Release Medical Records ☐ Speak to /Discuss ☐ Both

Obtain Information From:

Name/Facility: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

Email: _____

☐ Release Medical Records ☐ Speak to /Discuss ☐ Both

By signing below, I hereby authorize **Pines Health Services and its authorized employees and agents** to Disclose/Obtain the following healthcare records and information about me (*check all that apply*):

- □ My complete medical record
- □ My medical record for the dates _____/_____/_____ to _____/_____/_____
- □ Other records (*specify*): _____
  _____

Disclosure Format: Select one preferred format:

☐ Paper ☐ Fax (up to 100 pages) ☐ CD ☐ Secure Email

Purpose of Release: Why is this needed?

☐ Transfer of Care Reason for transfer: _____
☐ Continuity of Care ☐ Personal Copy ☐ Disability/Insurance Application/Claim
☐ Legal Purposes ☐ Worker's Comp Claim ☐ Other _____

I specifically intend this authorization to include the disclosure of:

___ *(Initials)* - **Mental and behavioral health records and information maintained by licensed mental health treatment facilities or agencies, or related to mental health services provided by licensed mental health professionals.** Check this box if you wish this authorization to authorize the disclosure of mental and behavioral health information maintained by a licensed mental health treatment provider, agency or facility, including a psychiatric hospital or mental health unit of a hospital. You have the right to review your mental and behavioral health records at any reasonable time prior to authorizing their disclosure on this form.

___ (*Initials)* - **Substance abuse program records and information.** Check this box if you wish this authorization to authorize the disclosure of information maintained by a substance abuse program, including information and records maintained by substance abuse counseling professionals, substance abuse medical practitioners, and substance abuse units within general medical facilities from which you received diagnosis, treatment or referral for alcohol or drug abuse. If you authorize the disclosure of substance abuse program information, such information may not be redisclosed by the recipient of the information unless you provide your written consent or such re-disclosure is otherwise permitted by 42 C.F.R. Part 2. However, other substance abuse information documented in your general medical records created by your primary care provider or other providers (e.g., hospital emergency room providers) who are not substance abuse "programs," will be disclosed under this authorization to the extent that they are within the scope of the records covered by this authorization, even if you do not check this box.

___ (*Initials)* - **HIV (Human Immunodeficiency Virus) information and records**. Check this box if you wish this authorization to include the disclosure of HIV test results and medical records containing information related to HIV infection status, AIDS (Acquired Immune Deficiency Syndrome), and ARCS (AIDS-Related Community Services). If you check this box, you should understand that the disclosure of HIV/AIDS-related records and information could have adverse consequences for you, including the loss or denial of employment, health insurance benefits, or life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.

I intend 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.

This authorization shall expire one (1) year from the date of my signature below, unless earlier revoked by me or I enter an earlier expiration date or event 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 my 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 Pines Health Services in the manner described in Pines Health Services' Notice of Privacy Practices, except to the extent that any person has already acted in reliance on it. I understand that my revocation of this authorization may be the basis for denial of health benefits or other insurance coverage or benefits.
- Pines Health Services will not condition services or treatment on whether I sign this authorization.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- Pines Health Services will not receive any direct or indirect payment in exchange for the disclosure of my healthcare information without my authorization, except that Pines Health Services may, as allowed by law, receive payment for the disclosure of my healthcare information for the following purposes without my authorization: (i) certain public health activities, (ii) preparation and disclosure of data in connection with certain types of research, (iii) my treatment, (iv) certain healthcare operations, (v) certain activities undertaken by Pines Health Services' contracted business associates on Pines Health Services' behalf at Pines Health Services' specific request, and (vi) to provide me with a copy of my healthcare records. In the event Pines Health Services may receive payment for the exchange of my health information for any other purpose, I understand that Pines Health Services will notify me of that fact and seek my separate authorization to disclose my health information under such circumstances.
- I have the right to a copy of this signed authorization.

_____	_____	_____
Date	Print Name	Signature of Patient or Patient's Authorized Representative
_____	_____	_____
Date	Print Name	Authorized Representative's Legal Authority (e.g. healthcare power of attorney agent, guardian, healthcare surrogate, parent of a minor)