AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

(DISCLOSURE)

I, _____ _____ of _____
(Patient Name) (Date of Birth) (Address)
_____, herby authorize Hope Health, it's authorized employees or agents to disclose the following health care information to _____
_____.

(REQUEST FOR DISCLOSURE)

I, _____ _____ of _____
(Patient Name) (Date of Birth) (Address)
_____, herby authorize _____, it's authorized employees or agents to disclose the following health care information to: **HOPE HEALTH, 77 ELM ST, SUITE 4, CAMDEN, ME 04843; PHONE: 207-236-2201; FAX: 207-236-2203**

History & Physical _____
Discharge Summary_____
Operative Report _____
Pathology Report _____
Radiology and/or Lab _____
Office Visits/Treatment_____
Other _____

The purpose of this permission is _____

I understand that no information about subsequent diagnosis and treatment may be released without further authorization and that this release applies only to information concerning diagnosis and treatment to date. This authorization is valid for **one year**. I understand that I may refuse permission to release records or revoke permission by giving the office written instruction signed and dated by me. I understand that refusal or revocation of permission may result in improper diagnosis and treatment, denial of health benefits or insurance or other adverse consequences. I understand that some of the information may have already been released prior to the office receiving a notification of revocation. I understand that I am entitled to a copy of this authorization form.

If I have been diagnosed or treated for any of the following, I understand that the above third party named on this authorization needs my specific consent to disclose related information. I may cross out any of the following that do not apply:

1. I (DO/DO NOT) authorize disclosure of information about treatment or diagnosis of drug or alcohol abuse
2. I (DO/DO NOT) authorize disclosure of information about treatment of mental illness.
3. I (DO/DO NOT) authorize disclosure of information which refers to treatment or diagnosis of HIV infection or AIDS. I (DO/DO NOT) wish to review such information prior to its disclosure.

Signed: _____ Date: _____
(Patient)
Signed: _____ Date: _____
(Patient Representative*)
Witnessed: _____ Date: _____

*A parent or guardian is generally required to sign for a patient under the age of 18. Patients 14-17 should also sign. See IDD 20.041. 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 or next of kin. See IDD 20.060. Indicate capacity of representative.
Revised 01/28/2020