# Authorization to Release Health Information

Patient's Name: ______________________________ Date of Birth: ______________________________
(Please Print)

Patient's Address: ______________________________________________________________

Patient's Telephone Number: ______________________ Social Security Number: ______________________

FROM: ______________________________ TO: **Coastal Women's Healthcare**
**The Elevation Center**
**71 US Route One, Suite A**
**Scarborough, Maine 04074**
**Ph: (207) 885-8400 Fax: (207) 885-8499**

Address: ______________________________
______________________________

Ph: ______________ Fax: ______________

___ I authorize the release of **all** medical information.
___ I authorize the release of information from appointment on (date) __________ to (date) __________

**Health Information and Records Authorized to be Disclosed:**

___ Office Visits ___ Mammogram Reports/Films ___ Operative/Procedure Reports
___ Obstetrical Reports ___ Lab/Pathology Results ___ Sonogram/Ultrasound Reports
___ Other ______________

**Information to be disclosed will include any information in your records that was originally generated by other providers, unless you specifically exclude information for re-disclosure. I specifically exclude the following information: ______________________________**

**I understand my specific consent is required by state law to release related information that may be contained in the above records:**

| | | |
|---|---|---|
| **Mental Health** | ___ I DO Authorize | ___ I DO NOT Authorize |
| **Mental Health Services** | ___ I DO Authorize | ___ I DO NOT Authorize |
| **Alcohol and Substance Abuse** | ___ I DO Authorize | ___ I DO NOT Authorize |
| **HIV/AIDS** | ___ I DO Authorize | ___ I DO NOT Authorize |

**Purpose of Disclosure** ___ At My Request ___ Transfer of Care ___ Other: ______________

**Duration of Authorization: This authorization will expire on _______ (please specify date no later than 1 year from date of signing or receipt of revocation)**
You may refuse to authorize disclosure of some or all of your healthcare information. You will not be denied treatment unless your healthcare is solely for the purpose of creating health information for another person or entity pursuant to this authorization. However, your refusal may result in improper diagnosis or treatment, denial of coverage or a claim of health benefits/insurance or other adverse consequences. You may revoke this authorization at any time except to the extent that we have already taken action in reliance on it. Your revocation must be in writing and must be signed and dated by you and will be effective when received by our office. Revocation may result in denial of your health benefits or other insurance coverage or benefits. Your health information disclosed in accordance with this Authorization may be re-disclosed by the person or entity authorized to receive it. You are encouraged to contact the person or entity authorized to receive your health information to determine whether and to what extent your health information may be re-disclosed and your right to restrict further disclosures. The disclosures authorized by this Authorization are in addition to and not in limitation of the disclosures of your health information that are authorized by law and applicable regulations. You have a right to receive a copy of this Authorization.

**Signature of Patient or Personal Representative:** ______________________________ **Date**: ______________

**Authority of Patient's Personal Representative:**

___ Legal Guardian ___Health Care Power of Attorney ___ Parent of Minor Patient ___ Personal Representative of Deceased Patient
Attach Copy of Power Attach Copy of Certificate of Appointment