Authorization to Release Health Information

Patient's Name: ______________________ Date of Birth: ______________________

Patient's Address: ____

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

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

TO: ______________________
Address: ______________________
____
Phone: ____________ Fax: ____________

_____ I authorize the release of **ALL** medical information.

_____ I authorize the release of information **ONLY** from (date) ______to (date) ______.

Health Information and Records Authorized to be Disclosed:

____ GYN 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 as it pertains to:

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 __Personal Representative of Deceased Patient