

Coastal Women's Healthcare
96 Campus Drive, 3rd floor
Scarborough, ME 04074
Ph: (207) 885-8400 Fax: (207) 885-8499

Date Received: _____
Date Sent: _____
MR#: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Phone: _____

I hereby authorize the release of copies of my medical records concerning my illness, treatment or recommendations while a patient at the medical facility, **during the dates of:** _____

These records should be released:

From:

Coastal Womens Healthcare, PA

TO:

Name: _____ Phone: _____
Address: _____ Fax: _____

I request the following information be released (last three years unless otherwise specified):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Annual Exams | <input type="checkbox"/> Office Visits | <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Obstetrical Reports | <input type="checkbox"/> Lab Results | <input type="checkbox"/> Mammogram Films | <input type="checkbox"/> Procedure Reports |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Ultrasound Report | <input type="checkbox"/> Mammogram Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Sonogram Report | <input type="checkbox"/> Other _____ | |

If I have been diagnosed or treated for any of the following, I understand my specific consent is required by state law to release related information that may be contained in the above records:

<u>Mental Health</u>	_____ I DO Authorize	_____ I DO NOT authorize
<u>Alcohol and Substance Abuse</u>	_____ I DO Authorize	_____ I DO NOT authorize
<u>Mental Health Services</u>	_____ I DO Authorize	_____ I DO NOT authorize

Purpose of Disclosure (Please check either box below, but be sure to specify a reason if you choose other)

- At my request. --The charge for a copy of your record is \$10 for the first page and 35¢ for each additional page. There will also be a separate postage charge for mailed records. Payment is due in full prior to the release of the medical record.
- Other (please specify) (e.g. to provide ongoing treatment, transfer of care, insurance application, etc):

I understand I may revoke all or part of this authorization by notifying CWHC. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim of health benefits or other adverse consequences. I may cross out any words on this authorization with which I disagree. I may have a copy of this authorization upon request. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. If I refuse to sign this authorization I understand my records will not be released. This authorization will expire 90 days from the date I sign this form.

Signature of Patient or Legal Representative Relationship to Patient Date

It may take up to 15 business days to complete request.

Charges are as follows: \$10.00 for the first page , \$0.35 per additional page. Certified copy \$30.00. There are no charges for provider to provider care. Visa, Mastercard and checks accepted. **Please present a photo ID if picking up records.**