

HIPAA Compliant - AUTHORIZATION TO RELEASE HEALTH INFORMATION

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

Patient Address: _____

Patient Telephone Number: _____ Social Security # _____

I authorize the use or disclosure of health information about me as described below:

FROM: _____

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

I authorize release of information from _____ (date) to _____ (date)

Purpose of Disclosure: At My Request Transfer of Care Other: _____

Health Information and Records Authorized to be Disclosed:

- Office Notes Mammogram Reports Operative/Procedure Reports
 Obstetrical Reports Lab/Pathology Results Sonogram/Ultrasound Report
 Other (please specify) _____

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: _____

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

Drug or Alcohol Abuse

- I DO authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific consent.
 DO NOT

Mental Health

- I DO authorize disclosure of information which refers to treatment or diagnosis of mental health.
 DO NOT
I DO want to review this information before it is released. I understand that reviews must
 DO NOT be supervised.

Duration of Authorization:

This Authorization will expire on _____ (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*