



One Medical Center Drive  
P.O. Box 626  
Biddeford, ME 04005-0626

### AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

1. I authorize and/or request Southern Maine Medical Center to:

- release information to     obtain health care information from

\_\_\_\_\_ (Patient Name or Organization Name, Address, Telephone Number)

2. You are authorized to disclose or receive and discuss the following:

- History & Physical     Consultations     Operative Notes     Lab, X-Ray and Diagnostics  
 Discharge Summary     Emergency Room Records     Cardiology tests     Psychiatric Evaluation  
 Billing Records     Other (Specify) \_\_\_\_\_

3. Specify dates of records needed: \_\_\_\_\_

4. The purpose of disclosure is:

- At the request of the undersigned individual     To coordinate treatment efforts with other caregivers  
 For insurance purposes     At the request of an attorney  
 Other (Specify) \_\_\_\_\_

**I DO  I DO NOT  authorize the release of information relating to the diagnosis or treatment of ALCOHOL or DRUG ABUSE. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.**

**I DO  I DO NOT  authorize the release of information relating to the diagnosis or treatment of MENTAL HEALTH. If I authorize release of this information, I DO  I DO NOT  want to review this information before it is released. I understand that my review must be supervised. I understand that release of information may be necessary for reimbursement and that I may decide to pay for services myself rather than allow release of information.**

**I DO  I DO NOT  authorize the release of information relating to the diagnosis or treatment of HIV, ARC or AIDS**

This authorization expires:

- Six months from today     On \_\_\_ / \_\_\_ / \_\_\_ (enter date)  
 When the following event occurs: \_\_\_\_\_

I understand that:

- I can revoke all or part of this authorization at any time by notifying SMMC's Health Information Management Department as provided for in our Notice of Privacy Practices, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.
- I can refuse to disclose all or some of the information in my health care records.
- A refusal to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- SMMC may not withhold treatment if I refuse to sign this form, except as noted here: \_\_\_\_\_
- The information released may be subject to re-disclosure unless otherwise protected by law.
- I may have a copy of this form.
- I may cross out any words on this form with which I disagree.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or his/her legally appointed representative)    (Relationship to Patient)

Patient Name and Address: \_\_\_\_\_ DOB: \_\_\_ / \_\_\_ / \_\_\_

Patient/Representative Telephone Number: ( \_\_\_ ) \_\_\_ - \_\_\_ Verified Identification:  Verified by: \_\_\_\_\_