This authorization is to release and disclose Protected Health Information (PHI) pertaining to:

PATIENT INFORMATION

PLEASE PRINT

Must be fully completed

Name:

Date of Birth: Phone:

Address:

City: State: Zip:

Email:

WHO do you want to receive your information?

I hereby authorize Central Maine Orthopaedics | Spectrum Healthcare Partners to release medical records to:

Central Maine Orthopaedics
Spectrum Healthcare Partners

Name: Southern Maine Healthcare

Address: 46 Barra Rd

City: Biddeford State:ME Zip:04005

Telephone: Fax:

WHAT information do you want released?

- Indicate date(s) of service
- *(If no date range is entered we will release records for the last year of treatment with our providers.)*

What specific records/report(s) do you want released? Check appropriate boxes:

From:_____To:_____/Regarding _____

☐ Physician office visit notes ☐ Operative Reports ☐ Radiology Reports

☐ Other (specify):

HOW do you want your information delivered?

☐ Fax as above ☐ Mail as above

PURPOSE of release... why is it needed?

☐ Continuing care ☐ Transfer of care ☐ Personal use/Review

☐ Other (specify):

Fees may be charged in accordance with State and Federal Statutes

Authorization to Release Protected Information

I **DO** authorize disclosure of any information relating to **Alcohol and/or Drug Abuse Treatment** ☐ I **Do Not**

I **DO** authorize disclosure of any information relating to **treatment by a Mental Health Professional or Program** ☐ I **Do Not**

I **DO** authorize disclosure of any information which refers to **HIV Test Results, Status, or Treatment** ☐ I **Do Not**

Maine law requires our practice to inform you that disclosing your HIV infection status may have consequences, if it is misused, such as negative treatment in your personal life, at work, or by insurance companies. It can be important in providing you needed services and healthcare.

I Understand That:

* I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance, or other adverse consequences.

* I can revoke all or a part of this authorization at any time during this time period by providing written notice to the Health Information Management Department , **except** where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for the denial of health benefits, of other insurance coverage or benefits.

* I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.

* I understand that I am entitled to a copy of this authorization, upon request.

This authorization becomes effective immediately and shall expire on _____. If no date is given, this authorization will remain effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

Signature of Patient or Authorized Representative **Date / Time** **Printed Name**

If signed by other than patient, indicate legal relationship: