York Hospital
15 Hospital Drive
York, Maine
(207) 363-4321

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (p. 1 of 2)

PATIENT INFORMATION:

Patient's Printed Name: _____ Date of request: _____

Address: _____ Date of Birth: _____

_____

Home Phone: _____ Cell Phone: _____

Email: _____

Authorized Representative* making request (if other than the patient): _____
PRINT NAME LEGIBLY

***Authority of Authorized Representative:** ☐ Guardian ☐ Health Care Power of Attorney ☐ Health Care Surrogate
☐ Parent of Minor Patient ☐ Personal Representative of Deceased Patient's Estate

REQUEST RECORDS FROM (who has your records now):

I hereby authorize _____
(*York Hospital and/or Practice(s) name OR other medical facility and its authorized employees/ agents*)

Please provide Address and contact information when requesting records from any **outside medical facilities**:

_____ _____ _____
Address Phone Fax

TO RELEASE INFORMATION TO (who do you want to receive your records):

_____ _____
Name of person or entity Phone

Please check one:

☐ Mail to Address: _____

_____
City State Zip Code

☐ Email:_____ ☐ Fax #:_____

☐ Hold for pickup ☐ Discuss my Health Information verbally

INFORMATION TO BE RELEASED (*check all that apply*):

☐ My complete medical record ☐ My medical records for the dates _____/_____/_____ to _____/_____/_____
☐ Discharge Summary ☐ Lab Tests ☐ History and Physical Exam(s)
☐ Emergency Room Records ☐ Operative Reports/Consults ☐ X-Ray Reports/Films
☐ Physician Office Records ☐ Other records (*specify*):_____

14964

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION (p. 2 of 2)

I specifically intend this authorization to include the disclosure of (*initial all that apply*):

[____] **Mental and behavioral health records and information maintained by licensed mental health treatment facilities or agencies, or related to mental health services provided by licensed mental health professionals**.
I understand that I have the right to review my mental and behavioral health records at any reasonable time before deciding to authorize their disclosure on this form.

[____] **Substance abuse program records and information**.

[____] **HIV (Human Immunodeficiency Virus) records and information.** *I understand that authorizing the disclosure of HIV records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.*

I intend this authorization to include the disclosure of records and information the disclosing facility or provider has received from other healthcare providers or facilities. I authorize that subsequent disclosures of information within the scope of this authorization may be made pursuant to this same authorization.

I authorize the disclosure of the above information for the following purpose(s):

☐ At my request
☐ Treatment, coordination or continuity of care
☐ Transferring to new provider
☐ Legal matter or proceeding
☐ Insurance coverage or payment for care and services
☐ Other purpose (*specify*): _____

This authorization shall expire one (1) year from the date of my signature below, unless earlier revoked by me or I enter an earlier expiration date or event here: _____

By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of the above healthcare information but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying York Hospital in the manner described in York Hospital's Notice of Privacy Practices (except to the extent that any person has already acted in reliance on it), but that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- York Hospital system will not condition services or treatment on whether I sign this authorization.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- A fee for the cost of processing this request may be charged.
- I have the right to a copy of this signed authorization.

Sign here _____ _____
Signature of Patient or Patient's Authorized Representative* Date

OFFICE USE ONLY: INFORMATION RELEASED BY:	OFFICE USE ONLY: INFORMATION RELEASED BY:	OFFICE USE ONLY: INFORMATION RELEASED BY:
_____ Date: _____ Practice or Department	_____ Date: _____ Practice or Department	_____ Date: _____ Practice or Department
METHOD:	**METHOD:**	**METHOD:**
☐ In person ➔ ☐ ID verified	☐ In person ➔ ☐ ID verified	☐ In person ➔ ☐ ID verified
☐ Fax ☐ Mail ☐ Email	☐ Fax ☐ Mail ☐ Email	☐ Fax ☐ Mail ☐ Email
Staff initials: _____	Staff initials: _____	Staff initials: _____