Authorization to Release Information [Please Print]

- This form is used to release your protected health information as required by federal and state privacy laws. If information is disclosed to a third party, the information may no longer be protected by the federal and state privacy laws and may be re-disclosed by the person or entity that receives this information.
- I understand that I can refuse to disclose some or all of the information in my treatment records. Refusal may result in the following; an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance, or other adverse consequences. I understand that I will not be denied treatment for refusing to disclose this information.
- I can cross out any provision on this form with which I disagree.
- This release does not include records generated at other facilities.
- I understand that I am entitled to a copy of this authorization, upon request.
- I may revoke this authorization at any time, in writing. If I wish to revoke this authorization, I will send my written request to Saco River Medical Group.

Section A. Patient Information: (individual whose information will be released)

Name: _____

(First, Middle, Last) (Maiden)

Address: _____

Date of Birth:	**Telephone Number:**

Section B. Sender: (person or organization that will send your information)

I authorize to release my protected health information as described below.

Section C. Recipient: (person or organization that will receive your information)

Person's Name or Organization:	**Telephone Number:**
Address: (including zip code)	

Section D. Description of the Information to be Released:

(what type of information will be released)

_____ **Specific Information as described on the line below:**
Initial _____

_____ **All medical records related to the provision of my health care services.**
Initial

- **I DO** authorize the disclosure of any information relating to the diagnosis or treatment of **Alcohol or Drug Abuse, Mental Health and HIV testing and results.** 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 NOT AUTHORIZE RELEASE OF SENSITIVE INFORMATION:_____ (Initial)

Purpose of Release: ☐ Personal ☐ Legal ☐ Continuation of care ☐ Transfer of care
Other: _____

Section E. Expiration: (will expire 1 year from the date of signing)

Section F. Approval:

(You OR an authorized person must sign and date this form in order for it to be complete)

Signature: By signing below, I authorize the release of my protected health information as described above.

_____ _____ ___/___/_____

Printed Name Signature of Patient (or authorized signer) Date