Memorial Hospital
MaineHealth

PATIENT'S AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT'S NAME:_____ DOB:_____ PHONE: _____

Hospital _____ Primary Care _____ Diabetes _____ Women's Health _____ Wound Care Center _____ Orthopedics _____ Surgery/Urology _____ Radiology _____

I authorize Medical/Clinical Information for the above patient, (please check only one box). **ONLY PROVIDE A PHYSICAL ADDRESS**

☐ To be sent **FROM** Memorial Hospital to the **FOLLOWING:**

☐To be sent **TO** Memorial Hospital from the **FOLLOWING:**

_____

_____

_____

_____

FOR THE PURPOSE OF: ☐Personal ☐Insurance ☐Continuation of care ☐Legal ☐Other_____

DATES OF CARE INCLUDE:_____to_____

☐ CD - ELECTRONIC MEDIA DEVICE (Default unless specified) ☐Paper **☐ UPS ☐ FAX ☐ PICK UP**

INFORMATION REQUESTED:

☐Complete Record ☐History and Physical ☐Discharge Summary ☐Operative Report ☐Laboratory ☐Image Reports ☐EKG ☐Consultations ☐ Emergency Room ☐Obstetrics ☐Pathology Only ☐Office Notes ☐Other _____

- I understand that this authorization may be revoked in writing and delivered to Health Information Services of Memorial Hospital at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
- I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining authorization AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
- Medical Records are available for pickup Monday through Friday from 9:00AM-4:00PM.
- Please allow 7 days for your request to be processed. You will be contacted by Health Information Services when your records are ready for pick-up or mailing.

EXPIRATION DATE: This authorization will expire 60 days from the date it was signed and is only valid for the above information requested.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information unless initialed here. I do not consent _____. (*Initials*)

_____ _____

Signature of individual or representative Date

_____ _____

[Authority or relationship of representative] Date

Request Processed by: **Initials:_____ Date:_____ _ Account#: _____ Pages: _____** **MH Form (33)-01 version 1 dtd July 2,2012**