Penobscot Community Health Care **Medical Records** P.O. Box 439 Bangor, ME 04402-0439 Phone: (207) 404-8101 Fax: (207) 990-1248 Email: PCHCMR@pchc.com	**Patient Name:** **Patient's Former Name or Alias:** **Patient Address:** **Date of Birth:** **Patient's Phone Number:**

Authorization to Disclose Health Information

By signing below, I authorize Penobscot Community Health Care (PCHC) and its staff (*check applicable box(es)*):

☐ To **DISCLOSE** my health information below **TO**: ***AND/OR*** ☐ To **OBTAIN** my health information below **FROM**:

Name of Person or Organization: _____

Mailing Address, including City/State/Zip: _____

Phone: _____ Fax: _____

By: ☐ Mail* ☐ Fax ☐ Email** (*specify recipient's email address*: _____)

☐ Verbal Communication ☐ Other (*specify instructions*): _____

** Records provided by mail will be sent on a compact disc, unless you specify other instructions.*

*** Records provided by email will be provided in Adobe PDF files that will be accessible to the email recipient via PCHC's secure messaging portal. An email will be sent to the email address you provide with instructions to the recipient on how to access such records via PCHC's portal.*

Health Information to be Disclosed

☐ My entire medical record (*complete "Sensitive Medical Information" section below if you wish sensitive types of health disclosed*)

☐ My medical records for the following dates _____ to _____

☐ Only the following specific types of medical records or information for the following dates: _____ to _____

☐ Clinical Records ☐ Immunization Records ☐ Lab Reports ☐ Hospital Records ☐ Radiology Reports ☐ Summary Records

☐ Other Records (specify): _____

Unless I strike out this sentence, I intend this authorization to include disclosure of records and information the above disclosing person or organization has received from other healthcare providers, facilities or persons, unless such information may be withheld by law (see note below).

Sensitive Health Information

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

[____] **Mental and behavioral health records and information**, including (i) records and information maintained by licensed mental health facilities, programs and agencies, and (ii) records and information related to mental health services provided by licensed mental health professionals. *I understand that I have the right to review any mental and behavioral health records maintained by licensed mental health facilities, programs or agencies at any reasonable time before deciding to authorize their disclosure on this form. (Note: licensed mental health facilities, programs and agencies may refuse to disclose information or records they have obtained from another individual or facility through an assurance of confidentiality, though you have the right to receive a summary description of such information.)*

[____] **Substance use disorder program records and information (subject to protection under 42 C.F.R. Part 2).**

[____] **HIV (Human Immunodeficiency Virus) / AIDS (Acquired Immune Deficiency Syndrome) information, including HIV test results, HIV/AIDS status, and medical records containing HIV/AIDS information.** *I understand that authorizing the disclosure of HIV/AIDS 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.*

Authorization of Continuing Communications and Subsequent Disclosures

Unless I strike out any of the following, I intend this authorization to authorize continuing communications and subsequent disclosures of information within the scope of this authorization (i.e., the disclosing and recipient parties of my health care information are authorized to have continuing communications concerning the health care information authorized to be disclosed by this form, and to disclose information covered by this authorization that was created or related to clinical encounters occurring after the date of my signature below).

I authorize the disclosure of the above information for the following purpose(s) (check applicable box(es)):

☐ At my request ☐ Treatment or Coordination of Medical Care ☐ Transfer of medical care ☐ Legal Matter or Proceeding

☐ Insurance coverage or payment purposes ☐ Other (specify): _____

PCHC	**Penobscot Community Health Care** **Medical Records** Ph: (207) 404-8101 Fax: (207) 990-1248 Email: PCHCMR@pchc.com	**Patient Name:** **Date of Birth:**

Duration or Expiration Date/Event: This authorization will expire thirty (30) months from the date of my signature below, unless earlier revoked by me or unless I enter an earlier expiration date or event here: _____ (date cannot exceed 30 months from date of signature). To the extent that this authorization authorizes disclosure of (i) mental health records and information maintained by a licensed mental health facility, program or agency, (ii) information concerning a child in a licensed residential care facility, or (iii) information concerning a child in a licensed foster care home, that part of the authorization will expire one (1) year from the date of my signature below, unless earlier revoked by me or unless I have entered an earlier expiration date or event in the space above.

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

- I may refuse to authorize the disclosure of some or all 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 PCHC in the manner described in PCHC's Notice of Privacy Practices (except to the extent that PCHC or any other 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.
- PCHC will not condition services or treatment on whether I sign this authorization, unless authorized to do so by law.
- 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.
- I have the right to a copy of this signed authorization.

_____ _____

Date Signature of Patient or Patient's Authorized Representative***

_____

Printed Name

Authorized Representative's Legal Authority: ☐ Legal guardian ☐ Health care power of attorney agent
☐ Health care surrogate ☐ Parent of a minor

*** Signature by an authorized representative certifies to PCHC that such person has the legal authority indicated to authorize disclosure of the patient's information and records on behalf of the patient.

FOR OFFICE USE ONLY

If the disclosure is by PCHC and the disclosure is partial or incomplete as compared to the patient's request, PCHC must notify the patient and recipient of the information that the disclosure is partial or incomplete by checking this box: ☐

If this authorization authorizes disclosure of substance use disorder program information protected by 42 C.F.R. Part 2:

Notice to Recipient of Prohibition on Redisclosure: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see §2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12(c)(5) and 2.65.

Received by: _____ Location: _____ Date: _____

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