Penobscot Bay
Medical Center
6 Glen Cove Drive, Rockport, ME 04856 - 4240

3/05

Request # __________________

MR #________________________

Processed____________________

WRITTEN AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, ____ Born: ______________________________
Patient Name (First, MI, Last, Maiden if applicable) Date of Birth (mm/dd/yy)

hereby authorize Penobscot Bay Medical Center and ____,

their authorized employees or agents ("Releaser"), to exchange healthcare information

I authorize Penobscot Bay Medical Center to release information from ________________(date) to _____________(date)

I authorize Penobscot Bay Medical Center to obtain information from __________________(date) to ________________(date)

Please specify applicable dates, illnesses, or other information, if necessary Circle report & specify date on line provided)

a. Emergency Room____________ b. Discharge Summary__________ c. History & Physical __________

d. Operative Report_____________ e. Pathology Report ___________ f. Radiology Report_____________

g. Lab Report ________________ h. EKG ______________ i. Occupational/Physical Therapy _____

j. Chemical Dependency Assessment _____________ k. Consult_____________ l. Social Work Assessment ________

____ All information as needed for reimbursement

Other information to be disclosed (specify):

____

Information that I refuse to disclose (specify): ____

The purpose of this release is for:___ Continuity of care or for :____

I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all such information listed above, except those items I have crossed out or specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Partial or incomplete records will be labeled as such. I understand that if that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization that receives the information.

PROHIBITION ON RE-DISCLOSURE: If this record contains information relating to the diagnosis or treatment of drug or alcohol treatment, the confidentiality of this information is protected by federal law (42CFR Part 2) This law prohibits further disclosures without the specific written consent of the patient.

This Authorization expires 1 year from the date hereof unless other state or federal laws apply. Subsequent disclosures by Releaser are permitted until expiration. However, I understand that I can revoke this Authorization at any time prior to the above time frame by notifying Penobscot Bay Medical Center, Medical Records Department, of the revocation. Such revocation will be written, or recorded, dated and shall be effective when received, subject to the rights of any person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits, and that I would be responsible for payment for services received. Please see Northeast Health Notice of Privacy for additional details. I understand that I am entitled to a copy of this authorization form.

If I have been diagnosed or treated for any of the following, I understand that Penobscot Bay Medical Center needs my specific consent to disclose related information. Please answer these questions by Circling "DO" or "DO NOT" indicating to the releasor that you authorize release/disclosure of said sensitive information.

I DO / DO NOT authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse.

I DO / DO NOT authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.

I DO / DO NOT authorize the disclosure of information which refers to treatment or diagnosis of HIV infection, ARC, or AIDS.

____
(Patient Signature or Authorized Representative/Relationship) (Date)

____
(Witness) (Date)