AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

Note: All applicable fields must be completed for this form to be considered valid.

MARTIN'S POINT® HEALTHCARE

Name of Patient: _____ **Date of Birth:** _____

RELEASE INFORMATION FROM	**RELEASE INFORMATION TO**
Name/Facility: **Martin's Point Health Care ATTN: HIM**	Name/Facility: _____
Address: **331 Veranda Street PO Box 9746 Portland, ME 04104-5040**	Address: _____
Phone/Fax: **Phone: 207-791-3728 / Fax: 207-828-2433**	Phone/Fax: _____

PURPOSE OF RELEASE

- ☐ Patient is Moving
  New Home Address: _____ New Phone: _____
- ☐ Transfer of Care to New Provider/Practice (Last Five (5) Years unless otherwise specified)
- ☐ Personal
- ☐ Legal Purposes
- ☐ Receiving Secondary Care
- ☐ Disability Determination
- ☐ Insurance Purposes
- ☐ Workers' Comp Claim
- ☐ Other:

INFORMATION TO BE RELEASED

- ☐ Last One (1) Year of Medical Records
- ☐ Last Three (3) Years of Medical Records
- ☐ Last Five (5) Years of Medical Records
- ☐ Immunization Records
- ☐ Office Visit Notes
- ☐ History and Physical
- ☐ Lab/Pathology Reports
- ☐ Radiology Reports
- ☐ Diagnostic Reports
- ☐ Consultation Reports
- ☐ Hospital Reports
- ☐ Payment/Claim Records
- ☐ Other Specific Records:

SENSITIVE INFORMATION TO BE RELEASED

I understand that the information to be released may contain sensitive information, and that unless I check the relevant line below, I hereby authorize release of the following types of information:

Information derived from services by a **mental health** professional ☐ I DO NOT Authorize
☐ I want to review such mental health information before it is sent

Information regarding **HIV** infection status ☐ I DO NOT Authorize

Information derived from a **substance use disorder** treatment facility/program ☐ I DO NOT Authorize

This authorization may be revoked at any time except to the extent any person has taken action in reliance upon this authorization. Further details on revocation of this authorization are included in the facility's notice of privacy practices. Revocation must be made in writing to the facility releasing the information. Revocation may be the basis for denial of health benefit or other insurance coverage or benefit. Information released pursuant to this authorization may be subject to rerelease by the recipient and may no longer be protected by federal or state law. A copy of this authorization is available on request.

Martin's Point Health Care will not condition treatment on the signing of this authorization. I may refuse to sign this authorization. If I refuse to sign this authorization, it may result in improper diagnosis, treatment, denial of coverage, denial of a claim for benefits, denial of other insurance, or other adverse consequences. Martin's Point Health Care may condition enrollment in its health plans on the signing of this authorization if the authorization is sought before my enrollment and used to make eligibility or enrollment determinations, or for its underwriting or risk-rating determinations. Under no circumstances will Martin's Point Health Care request or collect genetic information for enrollment or underwriting purposes.

This authorization expires **12 months** from the date hereof unless an earlier date or event is stated here: _____
I, the undersigned, hereby authorize the release of the protected health information described above subject to the restrictions described above:

Signature: _____ Date: _____

Printed Name of Person Signing (if not patient): _____

Relationship to Patient (if not patient): ☐ Parent ☐ Legal Guardian/Conservator* ☐ Health Care Power of Attorney*

*Copy of court order or Power of Attorney REQUIRED