CALAIS COMMUNITY HOSPITAL
24 Hospital Lane
Calais, ME 04619

Medical Record #: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Calais Community Hospital or _____ is hereby authorized
Name of Other Entity

to disclose my health information with: _____

Name of person/entity information is to be released to

_____

Address (Street, City, Zip) and Telephone Number (if known)

Patient's Name: _____ Date of Birth: _____ SSN: _____

I authorize the following information for the dates of _____ to be released:

___ Discharge Summary ___ Operative Report ___ History/Physical Exam ___ Pathology Report

___ Radiology Report ___ Radiology Films ___ Laboratory Report ___ Billing Information

Other: _____

This information is being release for the following purpose(s): ___ Continued medical care; ___ Marketing endeavors by the hospital (if marketing involves direct or indirect remuneration to the hospital from a third party); ___ Legal Purposes; ___ Personal Use; __ Other reason:_____

- ✓ I may revoke all or part of this authorization at any time by notifying the Health Information Management Department in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation. The revocation must be signed and dated.
- ✓ I may refuse to disclosure some of my health information.
- ✓ I understand the refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- ✓ I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. (42 CFR Part 2 prohibits unauthorized disclosure of substance use disorder records).
- ✓ I am entitled to a copy of this authorization and may inspect or copy the information to be disclosed.
- ✓ If I have any questions about this disclosure, I can contact the Health Information Department.
- ✓ I understand that I may be required to pay a reasonable fee for copying and retrieving these records.

I must specifically consent to release the following information. **CIRCLE** the appropriate word(s):

1. I **DO DO NOT** authorize disclosure of **substance use disorder records.**
2. I **DO DO NOT** authorize disclosure of **mental health information created by a mental health professional.**
3. I **DO DO NOT** wish to review such information prior to its release. This review must be supervised.
4. I **DO DO NOT** authorize disclosure of information regarding HIV infection status or any HIV test.

This authorization expires 90 days from the date signed.

_____ _____ _____
Witness Patient or Legal Representative (Identify Relationship) Date

Photo ID reviewed: _____ Copy provided to Requestor: _____