MAX HEALTH MAINE, LLC

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Patent's Address: _____

Patient's Telephone Number: _____ Social Security # _____

FROM: _____

Address: _____

_____

Ph: _____ Fax: _____

TO: MAX HEALTH MAINE, LLC
1226 Shore Road
Cape Elizabeth, Maine 04107
Ph: (207) 699-0901 **Fax: (207)699-0902**

PLEASE FAX RECORDS DO NOT MAIL
(If necessary, divide in multiple sections each less than 40 pages)

_____I authorize release of **ALL** medical information.

_____I authorize release of information from appointments on _____(date) to _____(date).

I request the following information be released (*last 3 years unless otherwise specified):*

___Discharge Summary	___Operative Report	___Inpatient Admission	___Pathology Reports
___History and Physical	___Lab Results	___Progress Notes	___Office Visits
___Consultation Reports	___Mammogram Reports	___Other_____	

I understand my specific consent is required by state law to release related information that may be contained In the above records:

Mental Health	__ **I DO** authorize	__ **I DO NOT** authorize
Mental Health Services	__ **I DO** authorize	__ **I DO NOT** authorize
Alcohol and Substance Abuse	__ **I DO** authorize	__ **I DO NOT** authorize
HIV/AIDS	__ **I DO** authorize	__ **I DO NOT** authorize

Purpose of Disclosure: __ **At My Request** __ **Transfer of Care** __ **Other:**_____

I understand that

* I can refuse to disclose some or all of the health care information in my treatment records, but that refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences. I understand I will not be denied treatment for refusing to disclose information.
* I can revoke all or part of this authorization at any time during this time period by written notice to Max Health Maine except where information has already been acted upon a request for the release of my medical record.
* I can cross out any provision on this form with which I disagree.
* I understand that if information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the person or entity that receives this information.
* I understand I am entitled to a copy of this authorization, upon request.

This authorization is effective for one year from the date of signing.
I further authorize future disclosures to the same individual and/or entities during this time period.

_____

Signature of Patient Date

_____

Signature of Legally Authorized Representative Relationship and Date

_____

Printed Name of Authorized Representative Witness