

MAX HEALTH MAINE, LLC
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____

Patient's Telephone Number: _____ Social Security # _____

FROM: _____

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

Address: _____

Ph: _____ Fax: _____

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:

<u>Mental Health</u>	___ I DO authorize	___ I DO NOT authorize
<u>Mental Health Services</u>	___ I DO authorize	___ I DO NOT authorize
<u>Alcohol and Substance Abuse</u>	___ I DO authorize	___ I DO NOT authorize
<u>HIV/AIDS</u>	___ 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 _____