Authorization To Release Protected Health Information (PHI)

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

MARTIN'S POINT HEALTH CARE

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

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

PURPOSE OF RELEASE (please select at least one)

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

TIME FRAME AND FORMAT

- ☐ Last One (1) Year of Records ☐ Last Three (3) Years of Records ☐ Last Five (5) Years of Records
- ☐ CD Format ☐ Fax Format ☐ Paper Format

INFORMATION TO BE RELEASED (please select all that apply)

- ☐ Immunization Records ☐ Lab/Pathology Reports ☐ Consultation Reports ☐ Other Specific Records:
- ☐ Office Visit Notes ☐ Radiology Reports ☐ Hospital Reports
- ☐ History and Physical ☐ Diagnostic Reports ☐ Payment/Claim Records

SENSITIVE INFORMATION TO BE RELEASED

I understand that the information to be released may contain sensitive information. I **authorize** the release of information **unless** I have checked any of the boxes below indicating otherwise:

I DO authorize the release of 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

I DO authorize the release of information regarding **HIV** infection status ☐ I DO NOT Authorize

I DO authorize the release of 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 (Martin's Point) 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 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 request or collect genetic information for enrollment or underwriting purposes.

This authorization expires **12 months** from the date of my signature below. During the 12-month period, Martin's Point may make subsequent disclosures to the recipient named above.

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

REV. 11/29/23