219 Capitol Street
Augusta, ME 04330
Phone: 207-213-6713
Fax: 207-213-6785

RELEASE OF PROTECTED HEALTH INFORMATION

This authorization is for use or disclosure of protected health information pertaining to:

NAME ___________________________

ADDRESS____

DOB / / **TELEPHONE ( ) -**

I AUTHORIZE FAMILY FOCUSED HEALTHCARE TO

GIVE (OR) **RECEIVE** MY HEALTH INFORMATION FROM

NAME ____

PHONE/FAX ( ) - ( ) -

ADDRESS

Release MEDICAL RECORDS: ALL

Release MEDICAL RECORDS FROM DATES: __________ to _____________

Release OTHER, PLEASE INCLUDE: ______________________________

PURPOSE OF DISCLOSURE: Referral Ongoing care Other

Circle to specify protected health information you require disclosed:

Treatment by Mental Health Profession or Program YES NO

Drug/Alcohol Abuse YES NO

If I received substance abuse or mental health treatment or a referral for such treatment from a health care practitioner or facility other than a substance abuse program or a licensed mental health facility, information about the substance abuse or mental health treatment I received from such practitioner or facility may be disclosed pursuant to my authorization to disclose general health care information.

HIV test results or status YES NO

If you circle YES, you should understand that persons who have disclosed HIV information have encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships. It can be important for providing you needed services and healthcare.

219 Capitol Street
Augusta, ME 04330
Phone: 207-213-6713
Fax: 207-213-6785

I UNDERSTAND THAT:

I am not required to sign this form. Signing this authorization is not a condition to treatment, payment, enrollment, and eligibility for benefits at FFHC.

That PHI release pursuant to this authorization may include records generated by another health care provider or facility.

I can cross out any provision on this form with which I disagree. I can refuse to disclose some or all of the information in my treatment records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage, or a claim for health benefits or other insurance or other adverse consequences.

That this release if valid for 12 months from the date of my signature unless I specify otherwise. I can revoke all or part of this authorization, in writing, at any time by delivering a written, dated, and signed notification or I can make an oral statement revoking this authorization to the facility indicated above except to the extent that FFHC has already acted in reliance on it.

I am entitled to a copy of this authorization, upon request.

Information disclosed pursuant to this authorization may be redisclosed by the recipient and therefore no longer protected by the privacy laws.

That I have the right to access and review this PHI prior to release. This review must be supervised by the office providing the PHI.

Maine law allows reasonable fees to be collected for copies of medical records which may not exceed processing costs. FFHC does not charge for copies of records provided to other care providers for continuing care or referral.

SIGNATURE: ______________________________________ DATE: ____________

(OR)

SIGNATURE OF REPRESENATIVE: ____________________________ DATE: ____________

NAME: ______________________ RELATIONSHIP: ________________