Patient Name_____

Date of Birth_____/____/_____

MILLINOCKET REGIONAL HOSPITAL
200 Somerset Street
Millinocket, Maine 04462
(207) 723-5161 Fax: (207) 723-3019

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

All spaces on this form MUST be completed for this release to be valid.

I, _____of _____, _____
(Patient) (City/Town) (State)
hereby authorize _____, its
(Name of Institution)

authorized employees or agents, to disclose the following information to: _____

_____
(Name of Institution or Person)
I authorize the release of only that information which is not crossed out below. Partial or incomplete records will be labeled as such.

a. History and Physical	g. Pathology Report	m. Treatment Plans
b. Social History	h. Progress Notes	n. Discharge Plan and Summary
c. Consult Notes	i. Therapy Notes	o. Patient Additions
d. Diagnosis/Problem List	j. Care Conference Notes	p. Responses to Patients Additions
e. Lab Results	k. Family Conference Notes	q. Records of Other Providers
f. Medication List	l. Office Notes	r. Others(specify):

Other information to be released:_____

The reason I am requesting these records to be released is:

_____for continuing care _____other(please specify)_____

I understand that my medical record contains information about my diagnosis and treatment. I may review my records. I may refuse permission to give out records or revoke permission by giving MRH Health Information Management written instructions signed by me and dated.

I understand that refusal or revocation of permission may result in improper diagnosis or treatment, denial of health benefits or insurance, or other adverse consequences. Revocation will not affect information already given out.

The permission is good until_____. MRH can give follow-up information during that period.

If I have been diagnosed or treated for any of the following, I understand that my specific consent may be needed to disclose related information. I may cross out any of the following which do not apply. In no event may any such information, if applicable, be disclosed without any specific consent. (PLEASE INITIAL BELOW IF YOU WISH TO DISCLOSE ANY OF THE FOLLOWING)

_____ I do authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be redisclosed by the recipient without my specific written consent.

_____ I authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARC OR AIDS.

_____ I do authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness.

_____ I do wish to review such information prior to its release.

Signed: _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Patient Representative*)

Signed:_____Date:_____
(Patient age 14 to 17)

Witness: _____ Date: _____

* A parent or guardian is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should also sign. See IDD 20.041. If an adult is unable to make or communicate medical decisions, then the following may sign in the priority given: agent under healthcare power of attorney, guardian, spouse, next-of-kin. See IDD 20.060. Indicate capacity of representative.