Central Maine Healthcare
The Central Maine Medical Family

Authorization to Release Medical Information

Patient Name: _____ **Date of Birth**: _____.
Address: _____ **Apt. #** _____.
City: _____ **State**: _____ **Zip Code**: _____ **Phone# (___)** _____.

I hereby authorize the release of copies of my medical records as indicated below:

FROM:
Name: _____ Phone# _____

Address: _____
_____ Fax# _____
_____

TO:
Name: _____ Phone# _____

Address: _____
_____ Fax# _____
_____

This authorization is limited to the following dates of treatment:

From: _____ To: _____

Would you like to receive this information electronically?* Yes _____ No _____
E-mail address: _____
*There is a $6.50 fee for e-disclose.

Information to be Used/Disclosed – Please check those that apply:
History and Physical ___ Discharge Summary ___ Operative Report ___
Laboratory Report ___ Radiology Report ___ Immunization Record ___
Clinical Offices (Practice Name)_____
Other (specify) _____

Protected Under State Law:

HIV/Communicable Disease	____ I DO authorize	____ I DO NOT authorize
Alcohol and/or Drug Abuse Treatment	____ I DO authorize	____ I DO NOT authorize
Mental Health Services	____ I DO authorize	____ I DO NOT authorize
Genetic Testing	____ I DO authorize	____ I DO NOT authorize

(Mental Health Services Provided by: A clinical nurse specialist; Psychologist; Social Worker; counseling professional; or a physician specializing in psychiatry licensed under the provision of Title 32.)

The Purpose for releasing this information is:
Attorney/Legal Case ____ Personal Use _____
Further Medical Care____ Transfer of Care (2 years of records sent unless otherwise specified) _____
Disability/Insurance Application/Claim ____ Other (please specify) _____

I understand I may revoke all or part of this authorization by notifying CMHC. This authorization will be retained as part of my medical record. I may refuse to disclose all or some of the information in my medical record. A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or claim for health benefits, or other adverse consequences. I may cross out any words on this authorization with which I disagree. I may have a copy of this authorization upon request. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person or organization that receives the information. If I refuse to sign this authorization I understand my records will not be released. There may be a charge for the processing of records. CIOX may handle the release of medical records. It may take up to 30 business days to complete request – 60 days fi the records are in storage. For billing questions, please call 1-800-367-1500.
This authorization will expire 90 days from the date I sign this form.

_____ _____ _____
Signature of Patient or Legal Representative **Relationship to patient** **Date**

**** For Office Use Only ****
Employee accepting request:_____ ID Checked ___YES ____ NO
Request Completed By: _____ Date: _____

Email form to: Central Maine Medical Center, HIM, 300 Main Street, Lewiston, ME 04240 or **FAX**: 207-344-0674