Maranacook Family Health Care

AUTHORIZATION TO RELEASE MEDICAL INFORMATION (1 of 2)

Patient Name (Print)	DOB

I authorize information to be released ❑ To: ❑ From:

Facility	
Physician	
Address	
Phone	Fax

I authorize information to be released ❑ To: ❑ From:

Maranacook Family Health Care
PO Box 310
Readfield, ME 04355

Purpose of Release:

❑ Changing Primary Care Dr. ❑ Other: _____

Type of Information to be Released

- ❑ Entire Medical Record (including any sensitive information as described below)
- ❑ A Summary ofMy Medical Record (which may include sensitive information as described below)
- ❑ Specific Information Only: _____

Sensitive Information:

I am aware that my medical record may contain sensitive information including drug or alcohol abuse diagnosis and treatment; sexually transmitted diseases and HIV/Aids testing or treatment; mental health diagnosis and treatment; sexual identity, preferences and practices; genetic testing and family history. I am aware that if I wish to exclude this or other information from release, then Maranacook Family Health Care will assist me in creating a release specific to my needs.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION (2 of 2)

This authorization expires in 90 days. I may revoke this release at any time before this expiration by notifying Maranacook Family Health Care. Information that is already in use for the purposes of treatment, payment or health care operations may not be retracted. I understand that once my medical information is released it may no longer be protected by privacy laws or by Maranacook Family Health Care.

Patient Signature	Date
Parent/Guardian Name (if other than self)	Relationship
Parent/Guardian Signature	Date