York Hospital
15 Hospital Drive, York, ME 03909
Phone: 207-363-4321 Fax: 207-351-2249

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Printed Name: _____ Date of request:_____
Address: _____ Date of Birth: _____
_____
Home Phone: _____ Cell Phone: _____
Email: _____

Authorized Representative* making request (if other than the patient): _____
PRINT NAME LEGIBLY

Authority of Authorized Representative: ☐ Guardian ☐ Health Care Power of Attorney
☐ Health Care Surrogate ☐ Parent of Minor Patient
☐ Personal Representative of Deceased Patient's Estate

I hereby authorize **_____ and its authorized employees and agents**:
(*York Hospital and/or Practice(s) Name*)

☐ To RELEASE TO: _____
Self /Person/Facility Address Phone Fax

☐ To OBTAIN FROM: _____
Person/Facility Address Phone Fax

The following healthcare records and information about me (*check all that apply*):

☐ My complete medical record ☐ My medical records for the dates _____/_____/_____ to _____/_____/_____
☐ Discharge Summary ☐ Lab Tests ☐ History and Physical Exam(s)
☐ Emergency Room Records ☐ Operative Reports/Consults ☐ X-Ray Reports/Films
☐ Physician Office Records ☐ Other records (*specify*):_____

I specifically intend this authorization to include the disclosure of (*initial all that apply*):

[____] **Mental and behavioral health records and information maintained by licensed mental health treatment facilities or agencies, or related to mental health services provided by licensed mental health professionals**. *I understand that I have the right to review my mental and behavioral health records at any reasonable time before deciding to authorize their disclosure on this form.*

[____] **Substance abuse program records and information**.

[____] **HIV (Human Immunodeficiency Virus) records and information.** *I understand that authorizing the disclosure of HIV records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.*

I intend this authorization to include the disclosure of records and information the disclosing facility or provider has received from other healthcare providers or facilities. I authorize that subsequent disclosures of information within the scope of this authorization may be made pursuant to this same authorization.

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I authorize the disclosure of the above information for the following purpose(s):

☐ At my request ☐ Treatment, coordination or continuity of care
☐ Insurance coverage or payment for care and services ☐ Legal matter or proceeding
☐ Marketing (*describe*): _____

If disclosure is for marketing purpose, York Hospital must complete prior to patient's signing: Does the marketing involve the direct or indirect payment of money or other remuneration to the disclosing provider/facility? ☐ YES ☐ NO

☐ Other purpose (*specify*): _____

If disclosure involves the sale of the patient's health care information (as defined by 45 C.F.R. §164.501), York must check this box prior to patient's signing: ☐ The disclosure of your health care information pursuant to this authorization will result in payment or other remuneration to the disclosing entity/person.

This authorization shall expire one (1) year from the date of my signature below, unless earlier revoked by me or I enter an earlier expiration date or event here: _____

By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of the above healthcare information but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying York Hospital in the manner described in York Hospital's Notice of Privacy Practices (except to the extent that any person has already acted in reliance on it), but that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- York Hospital system will not condition services or treatment on whether I sign this authorization.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- York Hospital will not receive any direct or indirect payment in exchange for the disclosure of my healthcare information without my authorization, except that York may, as allowed by law, receive payment for the disclosure of my healthcare information for the following purposes without my authorization: (i) certain public health activities, (ii) preparation and disclosure of data in connection with certain types of research, (iii) my treatment, (iv) certain healthcare operations, (v) certain activities undertaken by York's contracted business associates on York Hospital's behalf at York's specific request, and (vi) to provide me with a copy of my healthcare records. In the event York may receive payment for the exchange of my health information for any other purpose, I understand that York will notify me of that fact on this form or in another manner before seeking my authorization to disclose my health information under such circumstances.
- I have the right to a copy of this signed authorization.

_____ _____
Date Signature of Patient or Patient's Authorized Representative*

OFFICE USE ONLY: Medical Record completed by: _____ Date: _____	**OFFICE USE ONLY:** Medical Record completed by: _____ Date: _____	**OFFICE USE ONLY:** Medical Record completed by: _____ Date: _____