***HEALTH INFORMATION DEPARTMENT***

*11 Hospital Drive • Machias ME 04654*

*Phone:207.255.0229*

*Fax: 207.255.0214*

Patient Name: ________________________________________ Date of Birth: ________________

**I understand that health care information is confidential and will not be released without my authorization unless permitted by law. I understand that I have the legal right to refuse authorization to disclose all or some health care information, but refusal may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences. I understand that the Hospital will not condition treatment on my signing this authorization. I understand that I may inspect and copy the information to be disclosed** (there may be a charge for copies).

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**SECTION 1: Releasing/Requesting Information**

I hereby grant permission of the authorized employees or agents of **Down East Community Hospital** to release my health care or financial information to:

____________________________________________

____________________________________________

____________________________________________

The following information is to be disclosed:

Date(s) of service: _______________________________.
Specific information to be released:

- ☐ Emergency Room Record
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Laboratory Report(s)
- ☐ Bill with Diagnosis on it
- ☐ EKG/Cardiology Report(s)
- ☐ Verbal communication for treatment and/or discharge planning
- ☐ X-Ray/Radiology Report(s)
- ☐ Rehabilitation Therapy
- ☐ Respiratory Therapy
- ☐ Other: ___________________________

**SECTION 2: Purpose of the above release**

This information is to be used (check all that apply):

- ☐ To provide ongoing treatment/ aftercare
- ☐ Legal Matter (s)
- ☐ To coordinate treatment efforts with family/concerned others
- ☐ At the request of the individual (for personal use)
- ☐ Other: ____________________

__________________________

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**SECTION 3: Special consents** 

I understand that the party(ies) listed in Section 1 of the authorization need(s) my specific consent to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status.

**I DO authorize** the release of any information which referred to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization **unless I initial here______________.**

If I authorize the release of this information, I understand that the recipient of such information may not Further release this information without my specific consent or unless permitted by law.

**I do authorize** the release of any information which refers to the diagnosis or treatment of MENTAL HEALTH under this authorization **unless I initial here_____________.**

**I DO NOT** wish to review the material indicated before release **unless I initial here___________.**
If I have not initialed, it will be assumed that I do not wish to review the material.

**I do authorize** the release of any information which refers to the testing, diagnosis or treatment of HIV/AIDS **unless I initial here___________.**

**SECTION 4: Revocation and Expiration**

I have the right to revoke this authorization at any time; any revocation must be received in writing. Revocation will not cover information/material released prior to that date, but will prevent further release of information. I understand that revocation may be the basis for denial of health benefits or other insurance coverage.

This authorization expires **90 days** from the date it is signed. I authorize disclosures regarding these records to the individual or entity identified in Section 1 during this 90 day time period.

**SECTION 5: Signatures**

My signature below indicates that I have read this release form and have had the opportunity to have all my questions answered. I understand that information released by DECH might be further released by the receiving party noted in section 1, and that if this occurs, DECH cannot guarantee the protection of this information once disclosed.

I understand that I have a right to request a copy of this authorization.

__________________ ______________________________________________________

*Date* *Signature*

______________________________________________________

*Signature of representative**

*Indicate relationship to patient:

____ Parent

____ Legal Guardian

____ Other______________________________________

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For DECH personnel: Identification has been verified by: _____Driver's License _____Signature comparison _____Other

Requested information provided on__________________________by_________________________

Date Employee