MAINE MOBILE HEALTH PROGRAM
PATIENT'S REQUEST TO RELEASE OR OBTAIN HEALTH CARE INFORMATION

PATIENT NAME: _____

DOB: _____

ADDRESS: _____

_____

_____

INFORMATION TO BE RELEASED TO: *(check whichever one applies)*

{ } I request and authorize _____(Provider) to **release** my health care information, including my medical records, **TO** the following entity:

Name of Organization: _____
Location of Organization: _____
_____
Telephone Number: _____

OR

{ } I request and authorize _____(Provider) to **receive** my health care information, including any medical records, **FROM** the following entity:

Name of Organization: _____
Location of Organization: _____
_____
Telephone Number: _____

TYPE OF INFORMATION TO BE RELEASED:

General Release (limited to one (1) year of information unless otherwise requested).

Type of Record	Date(s) of Disclosure
{ } Entire Medical Record (excluding protected information)	____/____/____ to ____/____/____
{ } Discharge Summary	____/____/____ to ____/____/____
{ } Lab Results (list each request below)	____/____/____ to ____/____/____
{ } History & Physical	____/____/____ to ____/____/____
{ } X-Rays	____/____/____ to ____/____/____
{ } Operative Report	____/____/____ to ____/____/____
{ } Consultation Report	____/____/____ to ____/____/____
{ } Other Report	____/____/____ to ____/____/____

PROTECTED INFORMATION
PATIENT'S REQUEST TO RELEASE OR OBTAIN HEALTH CARE INFORMATION

{ } Substance Abuse	____/____/____ to ____/____/____
{ } Mental Health	____/____/____ to ____/____/____
{ } Communicable Disease	____/____/____ to ____/____/____
{ } HIV	____/____/____ to ____/____/____

In the space below please state any additional information relevant to the release

_____

_____

_____

_____

_____

_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and deliver the revocation to the MMHP Chief Privacy Officer. I understand that this revocation shall not be effective to any information already released in reliance on this authorization. I understand that this authorization to disclose health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal privacy rules.

_____ _____

Signature of Patient or Patient's Legal Representative Date

If Representative, please explain relationship to patient:

_____

{ } Check here if you wish the Maine Mobile Health Program to fax information.

Fax Number: _____

Due to confidentiality concerns we are reluctant to fax your health information as we cannot confirm the receiving fax is the intended recipient or that the fax's information shall be maintained.