**Authorization to Release Patient Identifiable Health Information**

CALAIS REGIONAL MEDICAL SERVICES
RURAL HEALTH CLINIC
37 Palmer Street
Calais, Maine 04619

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|---|---|---|---|
| **Phone (207)** | Ob/Gyn 454-3307 | Pediatrics 454-8195 | Adult Medicine 454-8195 |
| **Fax (207)** | ObGyn 454-3988 | Pediatrics 454-0955 | Adult Medicine 454-3840 |


I authorize CRMS to ___ provide, ____ exchange, ____ receive information as indicated below from my health records to/from (name/address):

_____
_____

___Discharge Summary ___History/Physical ___Operative Note ___Lab Report
___Pathology Report ___Radiology Report ___Verbal Communication
___Other_____

Dates of service: _____

**Purpose:** Continued medical diagnosis and treatment. Other reason: _____

I understand that my record contains information relating to my diagnosis and treatment. I authorize the release of all such information checked or specified above. I further understand that I may review my record and refuse authorization to disclose all or some of the above information, but that refusal may result in improper diagnosis or treatment, improper coverage of a health insurance claim or other adverse consequences. Partial or incomplete records will be labeled as such.
I understand that I may revoke all or part of this authorization at any time by notifying CRMS OB/GYN in writing. The revocation must be signed and dated. Revocation will not cover information/material released prior to that date, but will prevent further release of information.

_____

If I have been diagnosed or treated for any of the following, I understand that specific consent to disclose related information is required. I may cross out any words in this section with which I disagree.

1. I **(DO/DO NOT)** authorize disclosure of information which refers to treatment or diagnosis of **alcohol or drug abuse**. Such information may not be re-disclosed by the recipient without my specific written consent.
2. I **(DO/DO NOT)** authorize disclosure of information which refers to treatment or diagnosis of **mental health**. I **(DO/DO NOT**) wish to review such information prior to its release. Review must be supervised.
3. I **(DO/DO NOT)** authorize disclosure of information which refers to treatment or diagnosis of **HIV infection, ARC or AIDS**. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance and social and family relationships.

**This authorization expires 90 days from the date signed, and I authorize future disclosures regarding these records to the same individuals or entities during this time period.**

_____ _____ _____
Print Patient Name Date of Birth Patient Phone Number

_____ _____
Signature Patient, parent, or legal representative (Identify Relationship) Date

_____ _____
Witness Date

Revised 03/29/11