Requested by: _____________

37 College Ave, 156 Upton Hall
Gorham, Maine 04038
Ph: 207-780-5411 Fax: 207-780-4911

Authorization to Use and/or Disclose Medical Records

Name: ___________________________ **Date of Birth**: ___________________________

Telephone: ___________________________ **Student ID:** ___________________________

Obtaining or Releasing:

☐ **UHCS Releasing:**

☐ **UHCS Obtaining:**

To/From Facility:

Name: ____

Address: ____

City/State/Zip: ____

Phone: _______________________ **Fax:** ______________________

For the following purpose: **COORDINATION OF CARE** unless otherwise specified: ________________________________

Type and amount of information to be used or disclosed, and dates of service (if applicable): ________________________

____

The following five categories require additional authorization to release. I DO is assumed unless the DO NOT space is initialed. You may choose to initial as many, or as few, I DO NOT lines as you deem appropriate

<u>HIV status information</u>: I DO authorize the use and/or disclosure of health information related to testing, diagnosis or treatment of HIV, ARC or AIDS, pursuant to 5 M.R.S.A. Ch. 501. I DO NOT __________(please initial)

<u>Substance Abuse Treatment Information</u>: I DO authorize use and/or disclosure of health information related to treatment, testing or diagnosis of alcohol or substance abuse pursuant to 42 U.S.C.290dd-2 and 42 CFR Part 2. Treatment information disclosed pursuant to 42 CFR Part 2 may not be re-disclosed without the Individual's express written authorization or as otherwise permitted by law. I DO NOT __________(please initial)

<u>Mental Health Treatment Information</u>: I DO authorize use and/or disclosure of health information related to mental health treatment. Mental Health Treatment Information does not include "Psychotherapy Notes" under 45 CFR '164.501, which cannot be disclosed pursuant to this Authorization. I DO NOT __________(please initial)

<u>Sexually Transmitted Disease Information</u>: I DO authorize use and/or disclosure of health information related to testing, diagnosis or treatment of Sexually Transmitted Diseases. I DO NOT __________(please initial)

<u>Subsequent Disclosures</u>: I DO authorize subsequent disclosures to be made of the health information above. This does not apply to re-disclosure of alcohol or substance abuse treatment information disclosed under 42 CFR Part 2, under section (B) above. I DO NOT __________(please initial)

I UNDERSTAND THAT:

- **I have the right to review this information at any reasonable time, including prior to its release. Review must be supervised.**
- **I have the right to revoke this authorization at any time.**
- **if I revoke this authorization I must do so in writing and present my written revocation to Director of Health Services for USM Health Services.**
- **the revocation will not apply to information that has already been released in response to this authorization.**
- **revocation may be the basis for the denial of health benefits or other insurance coverage or benefits.**
- **this authorization will expire in 30 months.**
- **authorizing the disclosure of this health information is voluntary.**
- **I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable), except (a) if my treatment is related to research, then an authorization may be required; or (b) if the purpose of the health care is solely to create protected health information to be provided to a third party, then an authorization may be required.**
- **I may refuse to disclose all or some health information, but that refusal may result in improper diagnosis or treatment, denial of coverage or claim for health benefits or other insurance or other adverse consequences.**
- **Partial or incomplete disclosures, as compared to the information requested to be disclosed, will be labeled as such.**
- **I have a right to a copy of this authorization.**
- **any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules.**

If I have questions about disclosure of my health information, I may contact Director of Health Services for USM Health Services.

Signature: _______________________ **or** ___________________________ **Date:** ______________

(Patient) **(Guardian <18 years)**