Eastport Health Care, Inc.
30 Boynton St. Eastport, Maine 04631
Telephone: 207-853-6001 Fax: 207-853-6180

Authorization for Use and/or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this practice may not use or disclose of your individually identifiable health information without your authorization except as provided in our Notice of Privacy Practices. Your completion of this form means that you are giving permission for the use(s) or disclosure described below. Please **review** and complete this form carefully. **This authorization may be revoked at any time prior to release by notifying this facility. Such revocation must be in writing, signed, dated, and shall be effective when received.**

This health information may be used and/or disclosed by: _____

_____
(please specify name/address where health information will come from)

This health information may be disclosed to and used by: _____

_____
(name/address of facility or provider receiving your protected information)

You have the right to review any and all information before it is released.

The purpose of this authorization is: ☐ **Facilitate treatment and continuity of care** ☐ **Legal Issues** ☐ **Insurance**

☐ **Transfer of care** ☐ **To the individual for their own records/use** ☐ **Other: _____**

INFORMATION TO BE RELEASED: (Dental radiographs/records e-mail to: dental@eastporthealth.org)

____ Entire medical/dental record	____ Immunizations	____ Office Visit Notes
____ Lab/Pathology Reports	____ Radiology Reports/Images	____ Verbal Communication
____ Specific Illness or Injury	____ Other: _____	

Information I refuse to disclose: _____

HIV, MENTAL HEALTH, SUBSTANCE ABUSE INFORMATION

I understand that the information to be release may contain sensitive information. My specific authorization is necessary to release information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse, and or HIV/AIDS status. I understand that I have the right to review any health information before release of such information. **I authorize the release of potentially sensitive information by initialing the spaces below:**

_____ Mental Health (including anxiety and depression) _____Substance abuse _____HIV/AIDS

Printed Name: _____ Date of Birth: _____ Phone:_____
(patient name)

Patient Signature: _____ Date: _____
(if authorized representative, print and sign name)

This authorization expires _____ days/months from the date signed, unless revoked as described above.

FOR OFFICE USE ONLY

Date Received: _____ Received By:_____