Eastport Health Care Inc.
Machias Family Practice
53 Fremont Street
Machias, Maine 04654
(207) 255-8290 Fax (207) 255-4109

Patient Name:

Patient Former Name or Alias:

Patient Address:

Date of Birth:

Patient Phone:

Authorization to Release Health Information

I give my permission for EHC (Eastport Health Care) and its employees to:

☐ **Get** My Medical Information indicated below **FROM** ***OR*** ☐ **Send** My Medical Information indicated below **TO**

Name of Person or Organization: _____

City/State/Zip: _____

Phone: _____ Fax: _____

To be ☐ Mailed ☐ Faxed ☐ Emailed (if requesting secure electronic delivery) _____
Email Address

Dates of Care or Dates of Records

☐ **All Records** _____ (**Note:** check "All Records" ONLY if all medical records are needed. Sensitive Medical Information is not included unless selected below.)

OR I wish to release **Only those items selected below:**

☐ Clinic Records _____ ☐ Immunization Records _____

☐ Lab Reports _____ ☐ Hospital Records _____

☐ Radiology Reports _____ ☐ Summary Records _____

☐ Other Records _____

Sensitive Medical Information (Substance Abuse, Mental Health, HIV/AIDS): THIS SECTION MUST BE COMPLETED

I understand what may happen if I release the following sensitive information and have indicated which items I do wish to release and/or those I do not wish to release below.

Dates of Care or Dates of Records

☐ **I DO** / ☐ **I DO NOT** wish to release HIV/AIDS records _____

☐ **I DO** / ☐ **I DO NOT** wish to release Mental Health Treatment records _____

☐ **I DO** / ☐ **I DO NOT** wish to release Alcohol/Drug Abuse Treatment records _____ **(I understand this information cannot be redisclosed without my specific consent)**

I authorize the release of the Sensitive Medical Information selected above without review UNLESS I initial here _____.

The purpose of the disclosure is (check where applicable):

☐ Coordination of Medical Care ☐ Transfer of Medical Care ☐ Insurance ☐ Legal ☐ Disability ☐ School Entry ☐ Referral

☐ For Personal Use, please explain _____ ☐ Other, specify _____

Other Instructions: _____
Please use this space to indicate any special requests, information you do not wish disclosed, a different event or expiration for this Authorization, or any other instructions which may assist us with your request.

This Authorization is for ☐ a one-time disclosure OR ☐ multiple disclosures (Note: authorization for disclosure of certain mental health records cannot be continuing authorizations)

This Authorization expires: _____ Note: If left blank, this form will expire in ninety (90) days for one-time disclosures or in (1) year for multiple disclosures of health records. **Exception:** Six (6) months for children in residential and foster care.

Eastport Health Care Inc.
Machias Family Practice
(207) 255-8290 Fax (207) 255-4109

Patient Name:

Date of Birth:

This Authorization Form is voluntary and you may refuse to sign it. You may also cross out any words on this form that you do not agree with. Refusal to sign the form will not block your ability to receive health care services or payment for services; except that refusing to sign will mean you will not receive health services if those services are only to provide your Medical Information to someone else which requires a signed Authorization form. Refusal to sign this form may cause improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other negative outcomes. I understand that certain health information I authorize to be disclosed may be subject to redisclosure by the recipient and no longer protected.

You may have a copy of this form if you wish. In addition, you have the right to review the records before they are sent. You also have the right to receive a copy of the information requested in this form. Patients may receive a personal copy of these records at no charge, while a fee will be assessed for third party requests. The current prices are available where you receive care or by calling Medical Records at (207) 853-6001. The requested information will be sent within thirty (30) days of when you submit a completed form and pay any required fee.

- If you ask that copies of the requested information be sent by mail, EHC will send that information on a compact disc unless you have given other instructions.
- If you ask for e-mail copies of the information, you must provide a valid e-mail address. Your records will be given as Adobe PDF files on EHC's secure messaging portal. EHC will send an email to the email address you provide with instructions on how to access your Medical Information through the secure messaging portal.

You can revoke this authorization at any time by sending a written request to the person or entity that is sending us the records, or to us if we are the ones releasing your records to an outside entity or person. If you cancel this Authorization, it will not stop or change any action already taken by EHC or any other entity named in this release that was taken in reliance on this authorization and prior to receiving your notice to cancel. Canceling this form can cause denial of health benefits or other insurance coverage benefits.

I have read this Authorization form and I understand it. By signing below, I give my permission for EHC to release the Medical Information as described in this form and I release EHC, its employees, directors, officers and medical staff, from legal responsibility or liability for the release of the Medical Information.

Signed: _____ Date: _____
(Patient or Representative)

Print Name: _____

If not signed by the Patient, please indicate the authority to act for the patient: ☐ Parent ☐ Guardian ☐ Power of Attorney
[*Please attached proof of authority if signing as a guardian or under a power of attorney.]*

FOR OFFICE USE ONLY

Notice to Recipient of Prohibition on Redisclosure

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Notice Regarding Sensitive Medical Information

For persons/organizations receiving mental health information or HIV provided by EHC: This information has been disclosed to you from records protected by State confidentiality laws (22 M.R.S.A. § 1711-C(6)(A)(2) and/or 5 M.R.S.A. § 19201 *et seq.*). This information remains confidential and should not be disclosed any further except as expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law.

EHC Use Only: Received By: _____ Location: _____ Date: _____
Rev. 5/12/2021