

Mayo Regional Hospital
897 West Main Street, Dover-Foxcroft, ME 04426

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, authorize Mayo Regional Hospital, it's employees and
(NAME OF REQUESTER)
agents, to disclose and discuss the medical records of _____
(PATIENT'S NAME)

DOB: _____, with _____
(NAME and ADDRESS of PERSON or AGENCY)

Information I want disclosed includes: **Dates of Service:** _____;

Specific Information or Report(s): _____

_____.

This information may be used for the following purposes:
___ As authorized by the above-named patient
___ Ongoing treatment/aftercare for the above named patient
___ Other _____
(Statement regarding purpose of disclosure such as to lawyer, physician, insurance, etc)

Items 1, 2, and 3 Please check YES or NO if applicable or NA if not applicable

If I authorize the disclosure of information described under items 1, 2, or 3, I understand that such information cannot be re-disclosed by any other agent without my specific consent.

	YES	NO	NA
#1 I authorize use or disclosure of any information relating to the diagnosis or treatment of ALCOHOL or DRUG ABUSE under this authorization.	___	___	___
#2 I authorize use or disclosure of information relating to the diagnosis or treatment of MENTAL HEALTH under this authorization. If I authorize disclosure, I want to review this information before it is disclosed. (I understand that such review must be supervised)	___	___	___
#3 I authorize use or disclosure of information relating to the diagnosis or treatment of HIV INFECTION, AIDS-RELATED COMPLEX, OR AIDS , including the fact that a test was done. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the area of employment, housing, education, life insurance, health insurance, and social and family relationships.	___	___	___

My consent to disclose these records is effective for twelve months from this date and I authorize future disclosures regarding these records to the same individuals or entities during this time period. Recipients of this information must obtain reauthorization from me before re-disclosing information to anyone else and may no longer be subject to the privacy protections afforded by this facility. (over)

I understand that:

- I may revoke all or part of this authorization at any time by notifying Mayo Regional Hospital **in writing** with my signature and date of signed revocation, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.
- I may refuse to disclose all or some of the information in my medical records.
- A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I may cross out any words on this form with which I disagree.
- **The question of confidentiality between myself and Mayo Regional Hospital is hereby waived regarding the information disclosed by the signing of this document.**
- I will be given a copy of this completed authorization form.

Signed: _____ Date: _____
(Patient or parent if under 18 and not emancipated)

Signed: _____ Date: _____
(Personal representative, guardian, etc.)

Relationship to Patient: _____

To be completed by hospital personnel IF information was released:

The above information was given/mailed/faxed to the individual named on the other side
(circle one)
on _____ by _____.
(date) (name or initials of person releasing PHI)

List exactly what was released if not entirely specific on reverse side: _____

_____.

Number of Pages: _____