

**Mayo Practice Associates**  
897 West Main St Dover-Foxcroft, ME 04426

**PATIENT INFORMATION**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender M F

Legal Guardian \_\_\_\_\_ Marital Status S M D W

Address \_\_\_\_\_

Telephone (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Email Address \_\_\_\_\_ SS# \_\_\_\_\_

Preferred Method of Communication: \_\_\_\_\_ Race (voluntary) \_\_\_\_\_

Employers Name \_\_\_\_\_

Employers Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Is there a language/communication barrier?  NO  YES PCP \_\_\_\_\_

If yes please explain \_\_\_\_\_ Language Preference \_\_\_\_\_

Are you a veteran  NO  YES Are you a Migrant Worker  NO  YES

**HEALTH INSURANCE INFORMATION**

Primary Insurance Carrier \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Subscriber \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Subscriber \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group \_\_\_\_\_

I authorize Mayo Practice Associates to release my health care information, to the extent that is necessary, to my insurance carriers and their reviewers or others paying for this care. This authorization is valid as long as the individual has coverage with the insurer. In no event may this authorization exceed 30 months from the date of this release without written extension of this authorization.

I understand that: I may revoke all or part of this authorization at any time by notifying Mayo Practice Associates in writing, with my signature and date of revocation, subject to the rights of anyone who disclosed or received information prior to receiving my revocation.

I may refuse to disclose all or some of the information in my medical records.

A refusal to disclose all or some of the information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or adverse consequences.

I may have a copy of this form on request.

I may cross out any provision in this form with which I do not agree.

If I have been diagnosed or treated in a mental health, substance abuse treatment, or HIV infection, AIDS-related complex or AIDS program for any of the following, I understand Mayo Practice Associates needs my special consent to disclose related information. I may cross out any of the following which do not apply.

1) I (DO/DO NOT) authorize disclosure of the information which refers to treatment of or diagnosis of ALCOHOL OR DRUG ABUSE. If I authorize the release of this information, I understand that it cannot be re-disclosed by the recipient without my specific consent.

2) I (DO/DO NOT) authorize disclosure of information which refers to treatment or diagnosis of MENTAL HEALTH. I (DO/DO NOT) want to review this information before it is released. I understand that any such review must be supervised.

3) I (DO/DO NOT) authorize disclosure of information relating to the diagnosis or treatment of HIV INFECTION, AIDS RELATED COMPLEX, AIDS or HIV testing. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the employment, housing, education, life insurance and social and family relationships.

\_\_\_\_\_  
Patient or Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date