St. Mary's Health System St. Mary's Regional Medical Center Authorization for Release of Patient Records of Health Care Information – Return Fax: 207-777-8958

Provider's Name: _____ Provider's Phone: _____ Provider's FAX: _____

Address: _____ X-Ray #_____ Lab # _____

Patient Name: _____ Date of Birth: _____ Medical Record #_____

Street Address: _____ City, State, Zip: _____

I hereby authorize the above-named Provider and those physicians and other clinicians or those associated with or employed by their office in connection with my medical care to disclose my Health Care information to:

Purpose of Disclosure:

_____

Dates of Service: From _____ to _____Disclose only the following information (patient must indicate each item to be released/ obtained):

❑ Radiology Films ❑ Radiology Report ❑ Pathology Report ❑ Laboratory Report ❑ Laboratory and all other test results **except** HIV/AIDS mental health and/or drug substance abuse results ❑ Recertification ❑ Care Plans	❑ HIV/AIDS test/counseling records ❑ Physician orders ❑ Provider progress notes ❑ Nursing notes ❑ Facial Photo ❑ All Therapy Notes or select below: ○ Physical ○ Occupational ○ Speech ○ Cardiac	❑ Operative Notes ❑ Rehabilitation Notes ❑ Discharge Summary ❑ History & Physical ❑ Medical History ❑ Plan of Treatment ❑ Emergency Room Visit ❑ Dietary Records ❑ Nursing Assessments	❑ Mental Health History/Treatment ❑ Mental Health Discharge ❑ Psychiatric Medication ❑ Information relating to commitments, orders, application, and reports ❑ Alcohol/Drug Abuse Records limited to 6 months from date of Consent ❑ Sexually transmitted disease records ❑ Sexual/Alleged Sexual Abuse Records

Other (describe):

_____

Note - No substance abuse treatment or care information may be redisclosed; each disclosure requires the consent of the patient. All other information that I have authorized to be disclosed may be redisclosed to others consistent with the purposes above:

☐ Yes ☐ No.

The form in which the information is to be released:

☐ Written/photocopied/faxed ☐ Verbally ☐ E-Mail address: _____ ☐ Other (describe) _____

I understand that I can revoke (cancel) this authorization to disclose the above-referenced information at any time, except to the extent that disclosure has been made in reliance upon my authorization before revocation. In order to revoke my authorization, I must send a written notice to: **St. Mary's HIMS, P.O. Box 291, LEWISTON, ME 04243.**

This consent will expire Thirty (30) months from the date hereof, unless I have previously revoked this consent, or unless I have specified a shorter period for expiration of this Consent, as follows: _____ . I understand that I may refuse authorization to disclose all or some health information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. I also understand that if I revoke an authorization to disclose health care information that may be the basis for denial of health benefits or other insurance coverage or benefits. I know that I can review/print the St. Mary's Health System full notice of privacy practices from the **WWW.STMARYSMAINE.COM** website for more information about my right to revoke this authorization. I understand that I may receive a copy of this Full Notice of Privacy Practices as well as this authorization.

_____ _____ _____ _____

Witness Signature of Patient or Authorized Representative Print Name Date

Revised: 08.08.19