DFD Russell Medical Center (the "Health Care Provider")

Authorization for Use & Disclosure of Protected Health Information (PHI), including Personal Representative Signature

***Name of Patient/Individual*_____ *Date of Birth* _____**

***Address* _____**

***Telephone (h)* (_____)_____ *(w)* (_____)_____ *(other)*(_____) _____**

1) I hereby authorize the Health Care Provider and any employee or other member of the Health Care Provider's workforce to use and/or disclose the following:

(a) Complete Record. *****I DO _____ / DO NOT _____ (INITIAL ONE)*** authorize use and/or disclosure of my complete PHI/health care record.

****If (1)(a) is noted "I DO," then the Individual/Patient must also complete sections (b), (c) and (d), below, to authorize release of that type of PHI. Any sections not completed will be deemed refusal to authorize disclosure of that PHI.**

(b) HIV Status Information. ***I DO _____ / DO NOT _____ (INITIAL ONE)*** authorize use and/or disclosure of PHI related to testing, diagnosis or treatment of HIV or AIDS, pursuant to Maine law.

(c) Substance Abuse Treatment Information. ***I DO _____ / DO NOT _____ (INITIAL ONE)*** authorize use and/or disclosure of PHI related to diagnosis and/or treatment for alcohol or substance abuse.

(d) Mental Health Treatment Information. ***I DO _____ / DO NOT _____ (INITIAL ONE)*** authorize use and/or disclosure of PHI related to mental health treatment.

OR, if you intend to authorize use and/or disclosure of <u>specific PHI only</u>, complete 1(e), below:

(e) Other PHI. ***I DO_____ / DO NOT _____ (INITIAL ONE, if appropriate)*** authorize use and/or disclosure of specific health information ***(specify PHI, including relevant date(s) of treatment):***

_____

_____

2) The identified PHI may be used and/or disclosed **TO** the following person or entity**:**

Name & Address:_____

FROM the following person or entity:

Name & Address:_____

3) Purpose. The identified PHI may be used and/or disclosed for the following purpose(s):

_____

4) Redisclosure of Information. I understand that any information used and/or disclosed may be subject to redisclosure by the Recipient. *I DO_____/DO NOT_____* ***(INITIAL ONE)*** authorize subsequent disclosures to be made of the identified PHI.

5) Revocation. I understand that I may revoke this Authorization, in writing, at any time, by sending a signed, written notification of revocation to the Health Care Provider, as follows:

Medical Records at DFD Russell Medical Center, 180 Church Hill Road, Leeds, ME 04263

I understand that if I revoke this Authorization, it will not affect actions or disclosures already taken by the Health Care Provider in reliance on the Authorization prior to the Health Care Provider's receipt of the revocation. I understand that the revocation will not be effective if the Authorization was obtained as a condition of obtaining insurance coverage, to the extent that other law provides the insurer with the right to contest a claim under the policy or the policy itself. I also understand that revocation of this Authorization may be the basis for denial of health benefits or other insurance coverage or benefits. I understand that the exceptions to the right to revoke and a description of how to revoke this Authorization are included in the Health Care Provider's Notice of Privacy Practices.

6) Right to Refuse Authorization. I understand that I may refuse to authorize the disclosure of all or part of my health information, but such refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.

7) Authorization Not Required. I understand that the Health Care Provider will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, except: (a) if my treatment is related to research, then an authorization may be required; or (b) if the purpose of the health care is solely to create PHI to provide the PHI to a third-party, then an authorization may be required.

8) Expiration of Authorization. I understand that this Authorization shall be in effect until the date OR event set forth below, whichever occurs earlier, at which time this Authorization shall expire. Complete ONE of the following:

_____ **Date: (*Month/Date/Year*)** ____/____/_______; OR **Event: ___________________________________**

Note: Except as may otherwise be permitted under Maine law, this Authorization is NOT valid for more than one year from the date signed.

9) Copy of Authorization. I understand that I have a right to receive a copy of this Authorization.

This Authorization is voluntary.

NOTE: PLEASE MAKE SURE ALL APPLICABLE PARTS ARE COMPLETED.

Signed: ____

Print Patient's Name: ______________________________________ Date:__________________________

If not signed by the Patient/Individual, please provide the following information:

Personal Representative's SIGNATURE: ____

Name: ________________________________ Relationship to the Individual: ____________________________

Basis of authority to act as Personal Representative (such as Durable Power of Attorney, Appointment by Court, Parent of Minor, Guardian, Court Order):

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___ DFD Russell Employee check here if document conferring Personal Representative authority is in record (such as Durable Power of Attorney, Appointment by Court, Guardianship Order, other Court Order)