Mount Desert Island Hospital

Authorization to Disclose Protected Health Information (PHI)

For office use only
Medical Record #:

Patient Name:_____ **Date of Birth**:_____

Address:_____ Phone #: _____

City / State / Zipcode: _____ Cell Phone #:_____

I authorize the below entity to DISCLOSE my information:	**My information to be disclosed TO:**
☐ Mount Desert Island Hospital ☐ Person/Facility named below	☐ Mount Desert Island Hospital ☐ Person/Facility named below
Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone:_____	**Phone:**_____
Fax:_____	**Fax:**_____

INFORMATION TO BE DISCLOSED OR OBTAINED *(check all that apply):*

- Information referring to treatment or diagnosis of Mental Illness or Psychiatric condition - I DO ☐ DO NOT ☐ authorize disclosure of such information. I DO ☐ DO NOT☐ want to review this information before it is released.
- Information referring to the diagnosis, treatment, infection status, or test results for HIV infection, ARC, or AIDS - I DO ☐ DO NOT ☐ authorize disclosure of such information. This disclosure potentially could lead to discrimination in the areas of employment, housing, education, life insurance, and social and family relationships.
- Information referring to treatment or diagnosis of Substance Abuse (e.g. alcohol or drug). I DO ☐ DO NOT ☐ authorize disclosure of such information. (Federal drug & alcohol regulations, 42 CFR 2.31)

☐ History & Physical ☐ ER Report(s) (dates)_____ ☐ Entire chart ☐ Pathology Report(s) (dates)_____
☐ Discharge Summary ☐ EKG Report ☐ Consultation Report ☐ Labs:(dates)_____ ☐ X-rays: (dates)_____
☐ Operative Report ☐ Copies of pictures or video-tapes created during the course of my care
☐ Information on file from other healthcare providers/organizations (this is information from other facilities other than MDIH).
☐ Other:_____

PURPOSE OF THE DISCLOSURE:

☐ Further medical treatment ☐ Payment of a claim ☐ Legal Investigation ☐ Personal reasons
☐ Disability determination ☐ Application for insurance ☐ Other:_____

INFORMATION TO BE DELIVERED VIA: ☐ US mail ☐ Fax ☐ Pick-up – specify date:_____

This authorization is effective until _____ (authorization valid for one year from signature date if no date entered).

By signing this authorization, I understand the following:

- I understand that the provider will not condition treatment or deny me treatment if I do not sign this form. I may review my record before signing. I may refuse to sign this authorization form. Partial or incomplete information will be labeled as such. I understand that if I refuse to sign this authorization form, it may result in improper diagnosis of treatment, denial of coverage or a claim for benefits or other adverse consequences.
- I understand I may revoke this authorization at any time, except for information already disclosed. I understand that if I revoke this authorization, it may be the basis for denial of health benefits for other insurance coverage or benefits. To revoke my authorization, I will submit a written request to the medical record (Health Information) department.
- I understand that if information other than diagnosis and treatment for drug and alcohol abuse is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person, or organization that receives the information.
- I understand that I have the right to inspect and/or receive a copy of the information to be released and that I may be charged a fee for copies of the medical records I receive.
- I understand that I am entitled to a copy of this authorization form upon request.
- I understand the matters discussed on this form. I release the provider, its employees, officers and trustees, medical staff members, and business associates from any legal responsibility, or liability for the disclosures of the above information to the extent indicated and authorized herein.

Patient or Authorized Representative Signature:_____ **Date**:_____

Printed Name of Representative and Relationship/Legal Authority_____

☐ Data given/sent_____# of Pages Sent: _____

A photocopy or faxed copy of this form shall be considered as valid as the original.