women to women
Healthcare Center

Helping
women heal
themselves

3 MARINA ROAD
YARMOUTH, ME 04096
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Authorization for the Release of Information

I, the patient, hereby authorize the use or disclosure of my health information from the listed health practitioner as described below to the requesting practitioner. I understand that the health care information is confidential and will not be released without my authorization unless permitted by law. I understand that I have the right to refuse authorization to disclose all or some health care information, but refusal may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

Patient Information

Name _____ Date of Birth _____

Address _____

_____ Phone _____

Release Medical Records FROM:

Health Practitioner Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax Number _____

Release Medical Records TO:

Practitioner Requesting Information _____

Address _____

City _____ State _____ Zip Code _____

Phone _____ Fax Number _____

DURATION: This authorization shall become effective immediately and shall remain in effect until [date]_____, or for 1 year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Check the box for the type of information to be released and/or disclosed.

- ☐ General medical records from the last 2 years
- ☐ If record from more than the last 2 years are needed, please specify: _____
- ☐ Laboratory test results
- ☐ Physical Exams
- ☐ Progress Notes
- ☐ Radiology Films/Reports
- ☐ Consults
- ☐ Other(specify): _____

I understand that my specific consent is necessary to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment.

Please check the following specific authorization:

- ☐ I **DO** authorize _____ ☐ I **DO NOT** authorize …….. **AIDS/HIV**
- ☐ I **DO** authorize _____ ☐ I **DO NOT** authorize …….. **Alcohol and/or Drug Abuse Treatment**
- ☐ I **DO** authorize _____ ☐ I **DO NOT** authorize …….. **Mental Health Treatment**

_____ _____

Signature of Patient or Representative Date

☐ Parent ☐ Legal Guardian ☐ Other Legally Authorized Representative (Specify):_____