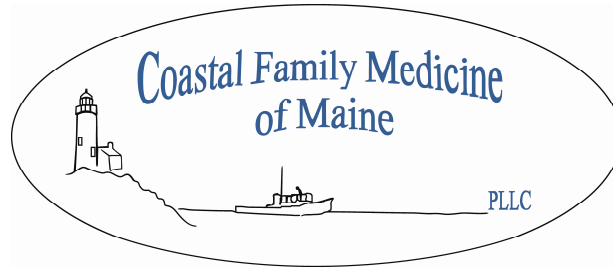


**Coastal Family Medicine of Maine, PLLC**  
**Authorization for Release of Medical Information/Records 03/09**



**Eastlight Building**  
**One West Lane, Suite B**  
**Blue Hill, Maine 04614-1207**

**Phone 207-374-5007**  
**Fax 207-374-5099**

**[www.CoastalFamilyMedicineofMaine.com](http://www.CoastalFamilyMedicineofMaine.com)**

I, \_\_\_\_\_  
[Individual or authorized representative]  
Of \_\_\_\_\_  
[ Address]  
\_\_\_\_\_ hereby authorize  
[City, State, Zip]

**Providers Name:** \_\_\_\_\_

to release, disclose, and furnish the following individually identifiable medical and health care information regarding my care and treatment to the **Coastal Family Medicine of Maine, PLLC, and/or its agents (hereafter CFMM):**

Patients Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Nature of Health Information to be released:

Entire Chart (inclusive of all categories below) Date: \_\_\_\_\_  
Laboratory/Pathology/Radiology Date: \_\_\_\_\_  
Other Date: \_\_\_\_\_

By checking below, I also authorize the release of the following portions of the health care records/information:

- \_\_\_ Mental health treatment records
- \_\_\_ HIV or AIDS related records *(Not including psychotherapy notes)*
- \_\_\_ Alcohol or drug abuse records
- \_\_\_ Medicaid records
- \_\_\_ Other \_\_\_\_\_

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**IMPORTANT:** If I have authorized the disclosure of **mental health treatment records/information**,

I do \_\_\_\_\_

I do Not \_\_\_\_\_

want to review these records/information before it is released. I understand that the review may be supervised or may need to be done by my representative.

**NOTICE** (applicable only if **substance abuse** records are disclosed): The information disclosed includes records protected by Federal confidentiality rules (42 CFR, part 2). The Federal rules prohibit recipients of such records from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**Term of Authorization:** Except as provided hereinafter, this authorization shall be effective from the date I have signed it until \_\_\_\_\_. [Cannot exceed 30 months]

**Revoking the Authorization:** I have been advised I have the right to revoke this authorization by contacting CFMM in writing to request this authorization be cancelled. If I revoke this authorization, the revocation will not apply to records/information that have been released before I notified the record keeper or CFMM in writing of my change of mind. I understand that my decision to revoke this authorization may impair CFMM's ability to adequately diagnose and treat your medical condition(s).

**Purpose of Authorization:** I also understand that CFMM utilizes the disclosed information for the purpose of providing appropriate medical care and treatment, including referral to third parties (i.e. sub-specialists or other medical providers) when deemed necessary.

**Re-disclosure:** I understand that the information used and disclosed in accordance with this authorization may be subject to re-disclosure by CFMM as described above and may no longer be protected by the federal privacy rule. However, I also understand that all individually identifiable health records/information provided to CFMM pursuant to this authorization shall be considered confidential under Maine state law and shall not be used by CFMM for any purpose other than that described above without my express written authorization, unless allowed by law.

**Copy of Authorization:** I acknowledge that I have retained a signed copy of this authorization. I agree that this authorization is as valid whether in the original, a photocopy, a facsimile, or in electronic form.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent Representative/Legal Guardian\*\*:

\_\_\_\_\_ Date: \_\_\_\_\_

**\*\* If you are signing on behalf of the individual, please state your relationship to the individual on the line above and attach a copy of the order or document that authorizes you to sign and authorize release of the patient's records.**