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 Providerôs 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 ñI DO,ò 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/AIDS 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>

I understand that if I revoke this Authorization, it will not affect actions or disclosures already taken by 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.

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 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 Patientôs Name: _____ Date:_____

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

Print Personal Representativeôs 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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