Health Information Management Department
Houlton Regional Hospital
Houlton, Maine

Authorization for Release/Receipt of Protected Health Information

Patient's Name:_____ MR # _____

Telephone #: _____ DOB: _____

I hereby authorize **Houlton Regional Hospital** to release/receive my health information as specified below:

Name and Address of the Person authorized to ☐Release ☐Receive the records: _____

I ☐**DO** ☐**DO NOT** authorize disclosure of information which refers to treatment or diagnosis drug or alcohol abuse.

I ☐**DO** ☐ **DO NOT** authorize disclosure of information which refers to the treatment or diagnosis of psychiatric illness.

I ☐ **DO** ☐**DO NOT** authorize disclosure of information which refers to testing, treatment, or diagnosis of HIV infection, ARC or AIDS.

A description of the information to be used or disclosed (if applicable, please specify time frames or visit dates to be released): _____
_____

Description of the purpose of the disclosure: _____

Expiration date of this authorization: _____
(Expiration may not exceed 30 months)

I understand that I may revoke this authorization at any time by notifying Houlton Regional Hospital, but if I do, it will not have any effect on the actions they have taken prior to my revocation. Requests to revoke this authorization should be sent to: Health Information Management Department, Houlton Regional Hospital, 20 Hartford Street, Houlton, ME 04730.

I understand that if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

I understand that I do not have to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment from Houlton Regional Hospital.

I understand that I may refuse authorization to disclose all or some health care information. Any revocation of this authorization or refusal to authorize disclosure of all or some health care information may result in improper diagnosis and treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.

I understand that under some circumstances, there may be a fee for the copying of the requested records, and that I will be told in advance if such a fee will apply to my request. I understand that I am entitled to a copy of this authorization form.

_____	_____	_____
Date/Time	**Signature of Patient or *Personal Representative**	**Relationship to Patient**
_____	_____	
Date/Time	**Signature of Witness**	

**Personal Representative (refer to Administrative Policy #316: Parents as Personal Representatives of Unemancipated Minors; #325: Personal Representatives;#520: Algorithm for Obtaining Consent for Treatment in the Event the Patient is Unable to Sign)* 3100792