AUTHORIZATION TO RELEASE

PROTECTED HEALTH INFORMATION (PHI)

This authorization is for use or disclosure of protected health information pertaining to:

Name:_____

Address:_____

DOB : _____ Phone: _____

I hereby authorize the following health care provider:

Name: _____

Address: _____

To *release* my protected health information to:

Fiddlehead Pediatric Healthcare/Dr. Erika Schumacher MD

116 Narrow Gauge Square, Suite 101

Farmington, ME 04938

207-956-0980 (ph)

833-654-0700 (PHI fax)

Protected health information to be released:

- Medical records (specify, can state "all"): _____
- Billing records

Time frame:

- Entire record
- Records from _____ (date) to _____ (date)

Check box and sign if you do NOT want the following PHI to be disclosed:

- Treatment by Mental Health Professional or Program _____ *[This includes records generated at a mental health agency/facility or by a psychiatrist, clinical nurse specialist, social worker or psychologist; records created by other physicians do not require specific authorization]*
- Drug/Alcohol Abuse _____
  [This includes records generated by medical personnel whose primary function is providing alcohol or drug abuse diagnosis, treatment, or referral and who are identified as such providers]
- HIV Test Results or Status _____ *[Maine law requires our practice to inform you that, if this information is misused, disclosing your HIV infection status may have consequences, such as negative treatment by insurance companies.]*

Expiration: This authorization becomes effective immediately and shall expire on: _____. If no date is given, this authorization is valid for **30 months** from signature date.

- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
- I understand that I have the right to access or copy the PHI described in this form by making a written request to the Privacy Officer of this practice: Hattie Huston Phone:207-956-0980. A copying fee may be charged as permitted by law.
- I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken in reliance on this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer at Fiddlehead Pediatric Healthcare. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
- I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer be protected by confidentiality laws.
- I understand that PHI that includes alcohol or drug program information protected by federal law will require notice to the person receiving the information that it may not be shown to or shared with others without my express written permission.
- I understand that I have a right to receive a copy of this authorization.

Signed: _____ **Date:** _____

Print name: _____

If signed by other than patient, indicate legal relationship: _____