AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient name: ____

Patient date of birth: ____

Patient phone number:____

Send information to:

Higher Grounds Women's Health
66 Leighton Road
Falmouth ME, 04105
Phone 207-331-6341
Fax 207-945-8073
DrLisa@highergroundwomenshealth.com

Information to be released from:
Provider name/ organization:____

Address: ____

Phone: ___________________________ Fax:__________________________________

Purpose of Disclosure:
▢Transfer of care* (This means that you will no longer be a patient at your previous PCP office)
▢Coordination of care
▢Other

Description of the information to be disclosed (check all that apply)

▢ENTIRE RECORD ▢OT/PT
▢Office Notes ▢Labs ▢Other:_______________________________
▢Operative Reports ▢Radiology reports

Disclosures requiring special consent: (check each box to provide consent for disclosure)
▢Treatment of substance abuse
▢Treatment or diagnosis of mental illness
▢Treatment or diagnosis of HIV related illness

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed and I may obtain a copy of this release. I understand that I may refuse to disclose all or some of the health information, however this may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits, and I understand that I have a right to revoke this authorization at any time. I must do so in writing and present it to the Health Information Management department. I understand that the revocation will not apply to information previously released. This authorization will expire in 6 months from this date and subsequent disclosures by Releasor are permitted until this expiration date.

I understand that any disclosures of information carries with it the potential for unauthorized redisclosures and the information may not be protected by federal confidentiality rules.

Date:_______________

Signature of patient or legal representative:____