AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

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

Name: ₓ
Address:_ ___
DOB :
 Phone: _____

I hereby authorize the following health care provider: _____

To obtain records from/ release records to Dr   Jean Antonucci
                                            115 Mt Blue Circle Suite 2
                                            Farmington ME 04938
                                            Fax 778 3544 ph 778 3313

Purpose of disclosure:
transfer of care

Protected health information to be released:
__X_Medical records (specify, can state "all"):   ___Billing records

Time frame:

__ entire record

___records from _____ (date) to _____ (date)

Your specific permission is required to disclose information regarding the following:
Check box and sign to specify protected health information to be disclosed
__Treatment by Mental Health Professional or Program   _____
    [Note: 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   _____
[Note to practice: 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, not general care 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 in your personal life or by insurance companies. It can be
important for providing you needed services & healthcare.)

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.

[*If mental health facility/agency/program, replace "30 months" with "one year")*

I understand that I am not required to sign this form and [*Jean Antonucci MD]* will not condition
treatment, payment for services, or eligibility for services on whether I sign this form.

I understand that my refusal to sign may result in improper diagnosis or treatment, denial of coverage for health benefits or other insurance or other adverse consequences

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: *Jean Antonucci MD.*A copying fee may be charged as permitted by law.

[*If mental health agency/facility/program, add: I have a right to review mental health records prior to the release of those records, within 3 working days of my request.]*

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 *Jean Antonucci MD]*. 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 redisclosed 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: X_____**Date:** X_

Print name: _
If signed by other than patient, indicate legal relationship: _____
Witnessed by:_anyone who watches a person sign can witness that they signed:_____