Pediatric Associates
of Lewiston

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

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

Patient Name:

Address:

DOB: Phone:

I hereby authorize the following health care provider:

Name: _____

Address: _____

To *release* my protected health information to:
Name: Pediatric Associates of Lewiston, PA
Address: 33 Mollison Way Lewiston, ME 04240
Phone: (207) 784-5782 Fax: (207) 783-9268
Email: kscott@pedihc.com

Purpose of disclosure:
- ☐ Changing Physicians (reason for transfer) _____
- ☐ Legal ☐ Other _____

Protected health information to be released:
- ☐ Medical records (specify, or can state "all"): ____
- ☐ Billing records

Time frame: ☐ entire record ☐ records from _____ (date) to _____ (date)

CONFIDENTIAL INFORMATION
Your specific permission is required to disclose information regarding the following:
☐ I do/☐ I do not ____ (initials): authorize the release of Treatment by Mental Health Professional or Program
☐ I do/☐ I do not ____ (initials): authorize the release of Drug/Alcohol Abuse
☐ I do/☐ I do not ____ (initials): authorize the release of HIV Test Results or Status
☐ I do/☐ I do not ____ (initials): authorize the release of Domestic Violence or Sexual Assault
☐ I do/☐ I do not ____ (initials): authorize the release of Genetic Testing Results
(Maine law requires our practice to inform you that disclosing your HIV infection status may have consequences, such as negative treatment in your personal life, at work or by insurance companies, if this information is misused. It can be important for providing you needed services & healthcare.)

- Continued -

My Rights:

- I understand that I am not required to sign this form and **Pediatric Associates of Lewiston** will not condition treatment, payment of 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**: Jenny Giles/ 33 Mollison Way, Lewiston ME 04240 207-784-5782**. 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 on 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 **Pediatric Associates of Lewiston**. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
- I understand the 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.

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.

Signed: _____ **Date:** _____

Print name: _____ **Phone Number**: _____

Relationship to Patient: _____

Witness Signature: _____

Rev. March 2015