MAINE CHI
MAINE COMPREHENSIVE HEALTH INSTITUTE

207-250-0255 fax: 207-692-1090 info@mainechi.com

Release of Medical Records Authorization Form

Patient Name: _____ Date of Birth: _____

Phone Number: _____ SSN:_____

I, _____ hereby authorize release of my protected health information:

From:

Office/Dr Name:_____
Address:_____
Phone:_____ Fax:_____

To:

Maine Comprehensive Health Institute
143 Silver Street, Ste 1 Waterville, ME 04901
Fax: 207-692-1090 Info@mainechi.com

Please send the following:

Lab Results Imaging Complete Record Other: _____

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires _____6 months _____one year from today's date, or upon the following specified event:

Signature:_____ Printed Name:_____

Date:_____ Relationship if applicable:_____