CHEST MEDICINE ASSOCIATES
The Pulmonary • Critical Care • Sleep Medicine Specialists

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I, _____, hereby authorize Chest Medicine Associates, its authorized employees or agents, to disclose and discuss records containing the following health care information to:

*Name: _____
*Complete Address: _____
_____
*Phone: _____ Fax: _____

Dates: From _____ through _____ OR: Entire record: _____
Information: All: __ Office notes: ____ Test results: ____ Sleep study: ____ Billing records: ____

Other information to be disclosed (specify): _____
Information that I refuse to release (specify): _____
The purpose of the release is: _____

I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all the information listed above, except those items I have crossed out or specified. I understand that I may review my records and refuse authorization to disclose al or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Partial or incomplete records will be labeled as such.

This Authorization expires _____ days/months from the date of my signature below (not to exceed 30 months), and any releases of information by Chest Medicine Associates are permitted until the date this Authorization expires. I can revoke this Authorization at any time before that expiration date, EXCEPT to the extent that any action has been taken in reliance on this Authorization. My revocation must be in writing, signed, dated and presented to the Privacy Officer at Chest Medicine Associates. It only becomes effective when it is received by the Privacy Officer. I understand that this revocation may be used to deny me health benefits or other insurance coverage or benefits.

If I have been diagnosed or treated for any of the following, I understand Chest Medicine Associates needs my specific consent to disclose related information I may cross out any of the following which do not apply.

1. Diagnosis or treatment by mental health professional or program. YES__ NO___ _____ (initials)
2. Diagnosis or treatment of drug and/or alcohol abuse. YES__ NO___ _____ (initials)
3. HIV test results or status. YES__ NO___ _____ (initials)

Maine law requires us to tell 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. This information can be important for providing you needed services and healthcare.

I understand that I am not required to sign this form and Chest Medicine Associates will not withhold treatment if I do not sign. I understand that I am entitled to a copy of this authorization form.

Signed: _____ Date: _____ SSN: _____ DOB: ____
Signed: _____ Date: _____
Authorized Representative

Witness: _____ Date: _____
Signature