St. Joseph Healthcare
St. Joseph Hospital
In the Spirit of Healing
Sponsored by Covenant Health Systems
Founded by the Felician Sisters

Patient Name:_____
Date of Birth:_____
Contact Phone #:_____

Written Authorization to Release Copies of Healthcare Information

I the undersigned, hereby authorize St Joseph Healthcare and its designated employees or agents to release/obtain/discuss medical information from my health record.

Where records are now (release from):		**Where records are going (release to):**	
Name:		**Name:**	Wabanaki Case Management Division of Cornerstone Behavioral Healthcare
Address:		**Address:**	PO Box 1356
City, State, Zip:		**City, State, Zip:**	Bangor ME 04402-1356
Phone:		**Phone:**	(207)992-0411
Fax:		**Fax:**	

The purpose of the release is for:

- ☐ Further care
- ☐ Transfer of care *(physician practices only)*
- ☐ Personal records *(i.e. further care; proactive/home file)*
- ☐ Attorney request *(reasonable fee may be assessed)*
- ☐ Other: _____

Date(s) of service – From:_____ To:_____

Please specify information to be released:
Physician Reports

- ☐ Office Treatment Notes
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Emergency Department
- ☐ Consultation
- ☐ Operative Report
- ☐ Psychiatric/Psychological Evaluation
- ☐ Psychosocial Evaluation
- ☐ Assessments/Care Plans/Notes

Diagnostic Reports

☐ Laboratory ☐ Radiology Reports ☐ Radiology Images (CD) ☐ Cardiology ☐ Pathology

Homecare & Hospice Reports

☐ Assessments ☐ Plans of Care ☐ Progress Notes/Summaries ☐ Medication Profiles ☐ Physician Orders

Other information to be disclosed (specify):_____
Information that I refuse to disclose (specify):_____

If I have been diagnosed or treated for any of the following, I understand that St. Joseph Healthcare needs my specific consent. I do authorize release of this information and waive the right to review records before they are released unless I have specifically initialed under the "I DO NOT" section in the table below.

I **DO** authorize release of information regarding **DRUG AND/OR ALCOHOL ABUSE**. By federal law, such information may not be re-disclosed by the recipient without specific written consent.	**I DO NOT** _____ (initial here)
I **DO** authorize release of information regarding **MENTAL HEALTH** treatment.	**I DO NOT** _____ (initial here)
I **DO** authorize disclosure of information regarding **HIV INFECTION, ARC OR AIDS**. I understand that individuals about whom such disclosures have been made have encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.	**I DO NOT** _____ (initial here)
I **DO** waive the right to review records before they are released. I understand that such review must be supervised.	**I DO NOT** _____ (initial here)

Continued on reverse

I understand that my treatment is not conditioned on signing this authorization. I will not be denied treatment if I do not sign this form. I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all such information listed above except those items I have crossed out or specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or claim for health benefits from other insurance(s) or other adverse consequences. Partial or incomplete records will be labeled as such.

If I am a parent or legal guardian requesting access to a minor's information, I further understand that I will not be provided access to records related to certain categories of treatment as required by law (for example, a minor's reproductive health records).

I understand that St. Joseph Healthcare may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I understand that in such cases, I may designate a representative to review my records on my behalf.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or organization that receives the information.

I understand that St. Joseph Healthcare will provide my medical records in the form or format I request (paper or electronic format). If this is not easily able to be produced, it needs to be produced in a machine readable electronic form or format that is agreed upon by myself and St. Joseph Healthcare.

I understand that St. Joseph Healthcare will notify me of its decision to approve or deny my request to access or obtain a copy of the requested information within thirty (30) days of receiving this request. If St. Joseph Healthcare is unable to comply with my approved request for information within thirty (30) days, it may extend the deadline for up to thirty (30) more days by notifying me in writing.

This authorization must be renewed annually. Subsequent disclosures by Releaser are permitted until expiration. However, I understand that I can revoke this Authorization at any time prior to the above time frame, except for the information already disclosed. To revoke my authorization, I will notify the appropriate Health Information Management Department. Such revocation must be in writing, signed, and dated and shall be effective when received, subject to the rights of any such person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis of denial of health benefits, insurance coverage, benefits, and/or other adverse consequences and that I would be responsible for payment for services received.

I understand that I am entitled to a copy of this authorization form.

Patient Signature	**Date & Time**
Authorized Representative/Relationship	**Date & Time**
Witness	**Date & Time**

HOSPITAL USE ONLY

MR#_____ Processed On:_____ By:_____