St. Croix Regional Family Health Center

136 Mill Street, Princeton, ME 04668

PH: 207-796-5503

FAX: 207-796-5528

www.scrfhc.org

RELEASE OF/REQUEST FOR INFORMATION - MEDICAL RECORDS

NAME: ______________________________ D.O.B. ______________

ADDRESS: ____

This information to be released to SCRFHC by:	*This information to be released by SCRFHC to:*
______________________	______________________
______________________	______________________
______________________	______________________

The purpose of this release is to

- ☐ Authorize both providers/facilities listed above to share information
- ☐ Release records for transfer of care of **medical** services
- ☐ Request records to be released to the person listed above
- ☐ To coordinate or provide clinical services

Information to be released from my medical record: *(Note: behavioral/mental health or substance related records require separate release)*

a. All Records ____

b. Only information related to: ______________________________________

c. Billing records: Time frame: ☐ Entire Record ☐ Records from ___________(date) to ___________ (date)

Please read the following statements indicating to the releaser to authorize or not authorize release/disclosure of sensitive information. Such information may not be re-disclosed by the recipient without my specific written consent.

Please check the appropriate box to authorize or not authorize the disclosure of the following information.

- I Do ☐ Do Not ☐ authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.
- I Do ☐ Do Not ☐ authorize disclosure of information referring to treatment or diagnosis of HIV, ARC, or AIDS.
- I Do ☐ Do Not ☐ want to review such information before it is released. I understand that any review must be supervised by designated staff.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate one year from the date of my signature. I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility. I understand that 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 I have a right to receive a copy of this authorization.

SIGNATURE OF PATIENT: ______________________________ PHONE: ______________

If signed by other than patient, indicate legal relationship: ______________ DATE: ______________

WITNESS: ______________________________ DATE: ______________

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RELEASE OF/REQUEST FOR INFORMATION - BEHAVIORAL HEALTH RECORDS

I, ______________________________ (client, parent or legal guardian), authorize and give my consent for the release of confidential information about ______________________________ (client).

This information to be released to SCRFHC by:	*This information to be released by SCRFHC to:*
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

The purpose of this release is to

- ☐ Authorize both providers/facilities listed above to share information
- ☐ Release records for transfer of care of **behavioral health** services
- ☐ Request records to be released to the person listed above
- ☐ To coordinate or provide clinical services

The specific information/material to be released is:

____ Treatment Plan/reviews	____ Psychological Reports	____ Clinical Summary	____ Diagnosis
____ Initial Assessment & Evaluation	____ Psycho-Social Assessment	____ Discharge Summary	____ Labs
____ Treatment Notes	____ Substance Abuse Info	____ Phone/verbal communication	

____ Other (specify): ______________________________

I understand that no confidential information or material will be released without my specific written permission except where allowed by federal or state law, in circumstances such as emergency health or safety, imminent danger to self or others, or by court order. *(Please see the Rights of Recipients of Mental Health Services for further information).* I further understand that I may review all such information/material and may cancel or revoke this authorization in writing at any time, except to the extent that action has already been taken under this release. If this authorization has not been revoked, it will terminate one year from the date of my signature.

1. I Do ☐ Do Not ☐ authorize disclosure of information that refers to treatment or diagnosis of drug or alcohol abuse. The recipient may not disclose such information without my specific written consent.
2. I Do ☐ Do Not ☐ authorize disclosure of information that refers to treatment or diagnosis of psychiatric illness.
3. I Do ☐ Do Not ☐ authorize disclosure of information that refers to treatment or diagnosis of HIV infection, ARC, or AIDS. I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, health insurance, and social and family relationships.
4. I Do ☐ Do Not ☐ want to review such information before it is released. I understand that any review must be supervised by designated staff.

______________________________ ____________ ____________
Signature of Client/Legal Guardian/Parent Client Date of Birth Date

______________________________ ____________
Witness Date

****

I am rescinding the above authorization as of ____________ ______________________
Date Signature

Revised 06/08/2022