Patient's Name:
Date of Birth:

Patient Identification

EASTERN MAINE MEDICAL CENTER
PO Box 404
Bangor, Maine 04402-0404

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I,____, give my permission for Eastern Maine Medical Center, its employees and agents to give information about my health care and health condition to the following:

Name:	Purpose:
RECORDS DEPOSITION SERVICE, INC.	**ENTIRE MEDICAL FILE**
PO BOX 5054, SOUTHFIELD, MI 48086-5054	**FOR DISCOVERY BEFORE TRIAL**
P: 248-357-3330 F: 248-357-3337	

EMMC can make copies to:

☐ Information arising out of this visit, admission or series of visits
☐ The following specific records (attach list if necessary) ____________________

Unless I revoke this authorization, it will expire in 12 months or upon the following date or event, if sooner:

____

This authorization is limited to existing records, or if applicable, those arising out of this visit, admission or series of visits. EMMC may discuss records with persons receiving them.

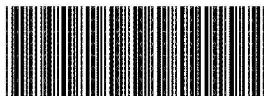
Other information to be given or other comments:____

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

1. I (**DO / DO NOT**) authorize disclosure of information about treatment or diagnosis of drug or alcohol abuse by the EMMC Chemical Dependency Institute. Such information may not be re-disclosed by the recipient without my specific written consent.

2. I (**DO / DO NOT**) authorize disclosure of information about mental health treatment or diagnosis. (see IDD 15.015) I (**DO / DO NOT**) wish to review such information prior to its release. Review must be supervised (*see back page). Recipient must be specified by name above.

3. I (**DO / DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of 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, and social and family relationships.



I understand that the Hospital will not condition treatment on signing this authorization. The Hospital will not deny me treatment if I do not sign this form. I may review my record before signing. I may refuse to sign this authorization form. Partial or incomplete information will be labeled as such. I understand that, If I refuse to sign this authorization form, it may result in improper diagnosis of treatment, denial of coverage, denial of a claim for benefits, denial of other insurance, or other adverse consequences.

I also understand that I may revoke this authorization at any time except for information already disclosed. To revoke my authorization, I will submit a written request to Eastern Maine Medical Center Health Information Services. I understand that, if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage.

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 redisclosed by the person or organization that receives the information.

I understand that I may have a copy of this authorization form. I decline a copy of this authorization unless I ask for one to be given to me.

I understand the matters discussed on this form. I release the Hospital, its employees, officers and trustees, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signed: ____ Date: _________
(Patient*)

Signed: ___________________________ Relationship:_________________________ Date: __________
(Patient Representative*)

*A parent or guardian is generally required to sign for a patient under the age of 18. Patients aged 14 to 17 should also sign. See IDD 20.041. If an adult is unable to make or communicate medical decisions, then the following may sign in the priority given: agent under healthcare power of attorney, guardian, spouse, next-of-kin. See IDD 20.060. Indicate capacity of representative.

Supervision of Review of Mental Health Treatment Records

All review of mental health treatment records by the patient must be supervised by treating clinician or designee and documented below:

1. Date of Review: ____________________
2. Name of Person Supervising Review:____
3. This review: ❑ Is routine
   ❑ Involves reasonable concern of possible harmful effect to the patient
4. If the review involves reasonable concern of possible harmful effect, was patient access to all or part of the record denied due to imminent danger to the physical or mental well-being of the patient?
   ❑ Yes ❑ No
5. If access was denied, explain the reason for denial and indicate the portion of the record subject to the denial:

   ____

   ____

____
Signature of Reviewer