



YORK HOSPITAL  
 15 Hospital Dr., York, ME 03909  
 (207) 363-4321

CONSENT FOR RELEASE OF  
 CONFIDENTIAL HEALTH  
 INFORMATION

Patient Label

I, \_\_\_\_\_ hereby request and authorize (check appropriate box):  
 [Patient Name]

- York Hospital
- York Hospital owned physician practice – specify practice name: \_\_\_\_\_
- Other Healthcare Facility – specify practice name: \_\_\_\_\_

to disclose Protected Health Information from the health records of:

**Patient name:** \_\_\_\_\_ **Medical Record #:** \_\_\_\_\_  
 (Or other identifiers)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize the release of Medical Records Information from: \_\_\_\_\_ (date) to:  
 \_\_\_\_\_ to be disclosed to: (company or person) \_\_\_\_\_  
 at: (address) \_\_\_\_\_

Phone # (if known) for recipient: \_\_\_\_\_ Fax # (if known) for recipient: \_\_\_\_\_

**SPECIFIC DESCRIPTION OF THE INFORMATION TO BE DISCLOSED:**

- Discharge Summary
- History and Physical Exam
- Operative Reports / Consults
- X-Ray Reports / X-Ray Films
- Physician Office Records
- Lab Tests
- Emergency Room Records
- Entire Medical Record
- Other (specify): \_\_\_\_\_

**SPECIFIC DESCRIPTION OF THE PURPOSES OF THE DISCLOSURE:**

- Continued Patient Care
- Insurance Coverage / Payment for Care
- Legal
- Worker's Compensation
- Other (specify): \_\_\_\_\_
- Patient (or authorized representative) Request



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CONSENT FOR RELEASE OF CONFIDENTIAL  
 HEALTH INFORMATION – PAGE TWO

Patient Label

I authorize the provider to use or disclose information related to (initial all that apply):

- AIDS/HIV and other Communicable Disease
- Behavioral Health Care / Psychiatric Care / Mental Health Information
- Alcohol and/or Drug Abuse Treatment

I understand that the record may contain information about identity, history and diagnosis, and has reference to mental health treatment and/or treatment for drug and alcohol abuse. Furthermore, I understand that if tested, the medical records will contain references to the laboratory results of testing for HIV Antibodies or Antigen (AIDS Test).

I understand that my records are protected under Federal Confidentiality Regulations (Section 2.31 of P.L. 93-282.42 CFR Part 2). They cannot be disclosed without my written consent at any time except as mandated by Federal Law.

I understand that the Hospital or Hospital owned Practice will not alter or deny treatment based on my signing of the authorization. The Hospital will not deny me treatment if I do not wish to sign this form. I have the right to refuse to sign this authorization form. I understand that, if I refuse to sign this authorization form, it may result in improper diagnosis or treatment, denial of insurance coverage or a claim for benefits, or other adverse consequences.

I also understand that I may revoke this authorization at any time, with some exceptions. For more details on when I can and cannot revoke this authorization, I can read the Hospital's Notice of Privacy Practices. I understand that, if I revoke this authorization, it may be the basis for denial of health benefits or other insurance coverage or benefits.

To revoke my authorization, I will submit a written request or I will call Patient Records at (207) 351-2184. Unless I revoke this authorization earlier, this authorization is valid for thirty (30) months from the date it is signed.

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

I understand that I may have a copy of this authorization form by asking the hospital for one.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, 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. I also understand that my records may be sent, if necessary, by "FAX" machine.

\_\_\_\_\_  
 Signature of Patient

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Time

\_\_\_\_\_  
 Signature of Legal Representative

\_\_\_\_\_  
 Relationship to Patient or description of  
 Authority to act for Patient.

Prepared by: \_\_\_\_\_

Date: \_\_\_\_\_