Andwell
HEALTH PARTNERS

Authorization to Release and Disclose Protected Health Information

Please complete all sections of this form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

Name:_____ **Date of Birth**:_____/_____/_____

I give permission for Andwell Health Partners to (check one):

☐ Both Release information to and Obtain from ☐ Release information to ☐ Obtain Information from

Name of Individual:_____ Facility/Organization:_____

Address:_____ City: _____ State:_____ ZIP _____

Phone:_____ Fax: _____ Email:_____

Reason for Disclosure: ☐ Continuing Healthcare/Treatment ☐ Transfer of Care ☐ For my records
☐ Disability/Insurance Application ☐ Legal Purposes ☐ Workers Compensation Claim
☐ Other (please specify):_____

Form of Disclosure: ☐ Flash drive ☐ Fax (up to 100 pages) ☐ Paper copy (up to 50 pages)
☐ Secure email ☐ Verbal

Dates of Disclosure: from _____/_____/_____ to _____/_____/_____ (will be 2 years if not specified)

Indicate the type of records to disclose:

☐ Andwell Home Health ☐ Andwell Hospice ☐ Andwell Caregivers
☐ Andwell Maternal and Child Health ☐ Andwell Mobile Wound Care ☐ Andwell Therapy Care
☐ Andwell Community & Behavioral Health ☐ Maine Center for Palliative Care
☐ Andwell Audiology ☐ Andwell Therapy and Early Learning Services

Please indicate the specific documents to release:

☐ Plan of Care/Treatment Plan ☐ Visit/Care/Progress Notes ☐ Discharge Summaries ☐ Assessments
☐ Invoices ☐ Other (please specify): _____

Mental/Behavioral Health Services: I DO authorize the receipt and/or disclosure of any information related to diagnosis and/or treatment of mental health. (If you want to review the mental health information before it is sent, initial here _____ (This review may be supervised.)	I DO NOT AUTHORIZE _____ (initial here)
Drug/Alcohol Treatment: I DO authorize the receipt and/or disclosure of any information relating to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization. **SPECFIC PROVISIONS REGARDING THE USE OR DISCLOSURE OF SUBSTANCE USE DISORDER RECORDS:** I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 CFR Part 2, the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a], and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that if I am authorizing the disclosure of my substance use disorder records to a Health Information Exchange pursuant to a general designation, I have the right to receive a list of all such disclosures made from the Health Information Exchange.	I DO NOT AUTHORIZE _____ (initial here)
HIV/AIDS Status/Test Results: I DO authorize the receipt and/or disclosure of information which refers to HIV Results, Infection status and/or Treatment.	I DO NOT AUTHORIZE _____ (initial here)

I understand:

- I may refuse to disclose all or some of the information in my medical record.
- I understand that my healthcare provider cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I may cross out any words on the form with which I disagree.
- A refusal to disclose information may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
- I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2 (see below), may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].
- I am permitted to revoke part or all of this authorization to share my health data at any time and can do so by submitting a request in writing to the Medical Records Department at Andwell Health Partners.
- I understand that in the event my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand I am entitled to a copy of this authorization, upon request.
- I understand that if the flash drive is not encrypted or password protected, it is my responsibility to take extra precautions to protect the data on the device and not to lose or misplace the device.
- I understand that unencrypted e-mail is not secure. There is a possibility that information included in an email can be intercepted and/or misaddressed/misdirected and read by other parties besides the person to whom it is addressed. By choosing to receive My Health Information on an unencrypted CD/disc, flash drive or by unencrypted e-mail, I am acknowledging and accepting these risks.
- This authorization to share my health information is valid for 12 months from the date of signing or upon discharge from services, whichever comes first. I authorize future disclosures to the individual/entity listed above unless I notify the Medical Records Department in writing that no future disclosures should be made.

Signature: By signing below, I acknowledge that I have read the above information, that I understand and agree with the statements and have been given the opportunity to have any questions addressed.

Patient Signature or Legally Authorized Representative Date

If signed by Authorized Representative, please state legal authority to act on behalf of patient

☐ Parent of a minor ☐ Guardian* ☐ Healthcare Power of Attorney * ☐ Personal Representative*

* Please provide documentation of authority

If you have questions or need assistance completing this form, please contact us at:

Andwell Health Partners

Medical Records Department

Phone: 207-795-9307 | Fax 207-795-9543 | medicalrecords@andwell.org

Updated 8.29.2024

Program: ALL/Open Packet: ALL/Electronic: Med Rec/LINK/Website