HOMETOWN
Health Center

118 Moosehead Trail, Suite 5
Newport, ME 04953
1-866-364-1366
hometownhealthcenter.org

# AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

(Please specify the appropriate practice at the bottom of this page by circling the practice.)

Name: _____ Date of Birth: _____

Address: _____ Social Security Number: XXX-XX- _____

Phone/Contact Number: _____

I authorize Hometown Health Center, its authorized employees or agents, to: ____Obtain from ____Release to

Name (Medical/Dental Facility, Provider etc.): _____ Phone: _____
Fax Number: _____

Address: _____

Indicate the information to be released:

___Medical/Dental ___Mental/Behavioral Health ___AIDS/HIV Testing & Treatment

*****___ ***Alcohol and Drug (needs 42 CFR Consent to Release Confidential Information.*** *****

___Medical records from Hometown Health Center (as specified): TO:_____ FROM: _____

___Lab Reports ___X-Ray Reports (all Imaging) ___EKG Reports ___Immunization Records ___ Allergy Records

___Assessments ___Progress Notes ___Treatment plans

**I DO / DO NOT** consent to the records being Faxed **I DO / DO NOT** wish to review records prior to their release

THE REASON THESE RECORDS ARE TO BE RELEASED IS:

__Continued Patient Care Leaving Practice & why: _____

__Legal/Attorney __Disability Determination __Insurance Claim/Application

OTHER: _____

State and Federal Laws require my specific consent to disclose information pertaining to HIV/AIDS testing or treatment, mental health treatment, and or substance abuse treatment information. I understand that I may request to review any information in my medical record, and may refuse to disclose some or all of my records. Such refusal may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits or other adverse consequences. I also understand that to insure confidentiality I may be asked to show a picture containing identification, such as a drivers' license. I realize this is for patient protection and to help insure patient confidentiality. I have read this form and I wish to have the designated medical information released. I will not hold the above named responsible for any misuse of this information that may occur. I may receive a copy of this release if I request.

*My consent to release these records is effective for **12 months** from the date this release is signed*. I authorize Hometown Health Center to make future disclosures regarding these records to the same individual or entities during the 12-month period.

SIGNATURE: _____ DATE: _____

(Patient or legally authorized representative. Please state legal authority of representative)

ADMINISTRATION USE ONLY:
Name of staff member sending records:_____ Date sent: _____

**DEXTER**
29 Church St.
Dexter, ME 04930
Phone: 924-5200
Fax: 924-7325

**DOVER-FOXCROFT**
1008 West Main St.
Dover-Foxcroft, ME 04426
Phone: 564-8710
Fax: 564-8715

*ADMIN OFFICE*
**NEWPORT**
118 Moosehead Trail,
Suite 5
Newport, ME 04953
Phone: 368-5189
Fax: 368-2451