Fern River Psychiatry

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

I hereby authorize Fern River Psychiatry, LLC to:

☐ ***Release information to:*** ☐ ***Obtain information from:*** ☐ ***Exchange information with:***

Name of Individual/Organization: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____ Zip Code: _____

The information to be released may be from my electronic health record (EHR) and/or paper medical records. I understand that the data from the EHR are current as of the date printed. I further understand that in reducing the data to paper, information from the electronic database is being reformatted onto paper and the page numbers reflect the printed document, not actual pages in the EHR.

INFORMATION PERTAINING TO:

☐ **All Records**
☐ Psychiatric Evaluations / Consultations
☐ Doctors Notes / Progress Notes
☐ Other (specify): _____

TIME FRAME: ☐ **Entire Record**
☐ Records from _____ (date) to _____ (date)

FOR THE PURPOSE OF: ☐ Coordination of care and ongoing psychiatric treatment
☐ Other: _____

Authorization to Release Protected Health Information

☐ **I DO** ☐ **I DO NOT**	Authorize disclosure of any information relating to **ALCOHOL and/ or DRUG ABUSE.**
☐ **I DO** ☐ **I DO NOT**	Authorize disclosure of any information relating to diagnosis and/or treatment of **Mental Health.**

50 Market Street, Ste 1A, #320, S. Portland, ME 04106
Phone: (207) 956-0050 Fax: (833) 606-1216
www.fernriverpsychiatry.com

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I understand that:

- I can refuse to disclose some or all of the health care information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.
- I can withdraw all or part of this authorization at any time during this time period by communicating my request to Fern River Psychiatry, LLC through written or verbal means, and except where this authorization already has been acted on for release of my protected health information. I understand that such revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
- If protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.
- I have the right to access or copy the protected health information described in this form by making a written or verbal request to Fern River Psychiatry, LLC. A copying fee may be charged as permitted by law. I have a right to review mental health records prior to the release of those records, within 3 working days of my request.
- I am entitled to a copy of this authorization, upon request.

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

_____ _____

Signature of Patient or Authorized Representative | Date / Time

_____ _____

Printed Name of Patient or Authorized Representative | Relationship of Authorized Representative

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