

**AUTHORIZATION TO USE OR DISCLOSE  
PROTECTED HEALTH INFORMATION**

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| <p><b>Information regarding patient for whom authorization is made:</b><br/>                 Full Name: _____</p> <p>Other Name(s) Used: _____ Date of Birth: _____<br/>                 Address: _____ City: _____ State: _____ Zip Code: _____<br/>                 Phone: (____) _____ Email (<i>Optional</i>): _____</p>   |  |
| <p><b>Health care provider or health care entity authorized to disclose this information:</b><br/>                 Name: _____</p> <p>Address: _____ City: _____ State: _____ Zip Code: _____<br/>                 Phone: (____) _____ Fax: (____) _____</p>   |  |
| <p><b>Health care provider or health care entity who can receive and use this information:</b><br/>                 Name: Coastline Direct Primary Care<br/>                 Address: 144 US Rt 1, Suite 4 City: Scarborough. State: ME Zip Code: 04074<br/>                 Phone: (207) 550-1278 Fax: (207) 466-8962</p>   |  |
| <p><b>Specific information to be disclosed:</b></p> <p><input type="checkbox"/> Medical Record from (insert date) _____ to (insert date) _____</p> <p><input type="checkbox"/> Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.</p> <p><input type="checkbox"/> Other: _____</p> |  |
| <p><b>Include: (<i>Indicate by Initialing</i>)</b></p> <p>_____ Drug, Alcohol or Substance Abuse Records</p> <p>_____ Mental Health Records (Except Psychotherapy Notes)</p> <p>_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)</p> <p>_____ Genetic Information (Including Genetic Test Results)</p>   | <p><b>Reason for release of information: (<i>Choose all that Apply</i>)</b></p> <p><input type="checkbox"/> Treatment/Continuing Medical Care</p> <p><input type="checkbox"/> Personal Use</p> <p><input type="checkbox"/> Billing or Claims</p> <p><input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> Legal Purposes</p> <p><input type="checkbox"/> Disability Determination</p> <p><input type="checkbox"/> School</p> <p><input type="checkbox"/> Employment</p> <p><input type="checkbox"/> Other (<i>Specify</i>): _____</p> |

**The individual signing this form agrees and acknowledges as follows:**

(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date:  
Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

(vi) **Timing of Release of Records.** I understand that the practice named above for whom I am providing this authorization will disclose the requested medical records indicated herein to the physician/entity named within fifteen (15) days from receipt of this authorization.

**SIGNATURES:**

Patient/Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_