



PO Box 1129, Greenville, ME 04441
207/695-5200 FAX 207/695-2254

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Social Security Number: _____

I authorize Charles A. Dean Memorial Hospital and Nursing Home and Northwoods Healthcare to exchange health care information to/from:

Name: _____

Address: _____

Information to be released: *includes only: (a) items not crossed out (b) items written in*

History and Physical	Diagnosis/Problem list	Consultation Reports
Discharge/Transfer Summary	Medication List	Operation Reports
Lab, X-ray, EKG Reports	Physician Office Notes	Social Service Notes
Pathology Reports	Treatment Plans	Therapy Notes
Emergency Room Record	Immunization Records	Patient Additions/Responses

Other Information (specify) _____

Time periods specified:

From: _____ To: _____ From: _____ To: _____

This information will be used for: _____

Partial or incomplete information will be labeled as such.

I understand that:

- I can revoke all or part of this authorization at any time by notifying Charles A. Dean Memorial Hospital and Nursing Home and Northwoods Healthcare in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.
- I can refuse to disclose all or some of the information in my treatment records.
- A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I can have a copy of this form upon request.
- I can cross out any provision on this form with which I disagree.
- I can review my record before signing.
- C.A. Dean will not condition treatment on signing this authorization. It cannot deny treatment if I refuse to sign.
- If this information is disclosed to a third party, it may no longer be protected by law from redisclosure by the recipient.

My consent to release these records is effective for 30 months (12 months for mental health) from the date this release is signed. I authorize Charles A. Dean Memorial Hospital and Nursing Home and Northwoods Healthcare to make future disclosures regarding these records to the same individuals or entities during the 30 month time period.

