Plastic & Hand Surgical Associates
244 Western Avenue, South Portland, ME 04106
(207) 775-3446 Fax (207) 879-1646

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I, ______________________________, authorize **Plastic & Hand Surgical Associates** and its authorized employees and agents to disclose and discuss my treatment records relating to

____
(Patient's medical condition or reason for seeking services)

with ____
(Receiving provider, individual or Entity)

Please forward:
- ❑ All of my treatment record information, including history, dates, course and summary of treatment received here.
- ❑ Treatment records on file from other health care practitioners.
- ❑ Statements I have added to my treatment records, with responses, if any.
- ❑ X-rays θ Photographs
- ❑ Only____.

My health care information which is the subject of this authorization to disclose includes information written or not, about the preventative, diagnostic, or treatment services provided to me and that may be used to identify me. Depending upon the services I request from Physician, this information may include information about the treatment for sexually transmitted diseases, mental health or psychiatric conditions, or substance abuse.

In the space provided below, please identify the specific health care information that you **do not** want disclosed.

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My consent to release these records is effective until the earlier of 1) the date in which the provider receives a written revocation of this authorization from me or 2) the date which is 30 months after the date of this authorization. I authorize future disclosures regarding these records to the same individuals or entities during this time period.

I understand that:
- I can revoke all or part of this authorization at any time by notifying the sending provider 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 to disclose all or some of the 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.

✕_____________________________________ _________________
Patient or Authorized Representative Signature Date

Patient's Social Security Number: _______________________________

Patient's Date of Birth: __________________________