Lifespan Family Healthcare, LLC

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT INFORMATION (Please Print):

Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

RELEASE MY MEDICAL RECORDS FROM:

DR. Name: _____ Business Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

SEND MY MEDICAL RECORDS TO:

Lifespan Family Healthcare
Medical Records Coordinator
80 River Road
Newcastle, ME 04553

Phone: 207-563-3366 Ext 9
Fax: 207-563-3393

REASON: □ Selected new physician in the area □ Second opinion/Consult □ Other
□ Change of insurance □ Moving out of town _____

PORTION OF RECORDS TO BE RELEASED:

□ Entire Medical Record □ Other _____
_____

Restrictions: I understand that the recipient of this information may not use this information except for the express purpose identified above, unless another authorization is obtained from me or unless such or disclosure is specifically required or permitted by law.

Notice: Unless specified below this authorization is for full disclosure of all records, including clinical findings, diagnoses, treatments, assessments, recommendations for further care, names of all health care personnel, dates of hospitalizations and ambulatory visits, charges and any information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including AIDS/HIV information.

Exclusions (please initial): _____ Drug/Alcohol _____ Sexually Transmitted Disease
_____ HIV/AIDS _____ Mental Health/Psychiatric

Patient signature: _____ Date: _____

A photocopy of this release is as valid as the original

I understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished.