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**: (please provide accurate information to avoid delays)
DR. Name: _____ Business Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

**SEND MY MEDICAL RECORDS TO**:

Lifespan Family Healthcare
Medical Records Coordinator Phone: 207-563-3366 Ext 7
80 River Road Fax: 207-563-3393
Newcastle, ME 04553

**REASON**: □ Selected new physician in the area □ 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

Signature of patient/parent or legal guardian: _____ Date: _____

Name of person signing and relationship to patient:_____

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.