Islands Community Medical Services

ICMS

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____

Address:_____ **Telephone:**_____

PERSONS OR ENTITIES DISCLOSING OR RECEIVING PROTECTED HEALTH INFORMATION

1.The Protected Health Information (PHI) identified below may be used and/or disclosed TO the following persons or entities. *Name & Address:*_____

_____

2. The Protected Health Information (PHI) identified below may be disclosed FROM the following persons or entities. *Name & Address:*_____

_____

3. PURPOSE. The identified Protected Health Information (PHI) may be used and / or disclosed for the following purpose (s):_____

_____

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SPECIFIC AUTHORIZATION TO DISCLOSE

I hereby authorize any and all of my health care practitioners and health care facilities to furnish, discuss, use and / or disclose the following:

1. **Complete Record.** I DO _____ / DO NOT _____ (INITIAL ONE) authorize use and/or disclosure of my complete PHI/health care record including all records of any other health care provider in the possession of the above named provider and all protected health information. (Note: Even if you select "I DO" please complete 2, 3, and 4 in this section. Failure to complete these sections is deemed a refusal to authorize the disclosure of that PHI.)
2. **HIV Status Information.** ***I DO _____ / DO NOT _____ (INITIAL ONE)*** **authorize** use/disclosure of information which relates to testing, diagnosis, or treatment of HIV infection, AIDS-related complex or AIDS, pursuant to Maine law.
3. **Substance Abuse Treatment Information.** ***I DO _____ / DO NOT _____ (INITIAL ONE)*** **authorize** use/disclosure of information which relates to treatment or diagnosis of substance (drug or alcohol) abuse.
4. **Mental Health Treatment Information.** ***I DO _____ / DO NOT _____ (INITIAL ONE)*** **authorize** use/disclosure of information which relates to treatment or diagnosis for mental health.
5. If you want us to only use and/or disclose specific protected health information complete the following:

   I (DO) authorize the use and disclosure of only specific protected health information which I am describing in detail below ***(specify PHI, including relevant date(s) of treatment)***:

   _____

UNDERSTANDING YOUR RIGHTS

I UNDERSTAND:

1. **Redisclosure of Information.** Any information used and/or disclosed may be subject to redisclosure by the Recipient and may no longer be subject to HIPAA's protections.
2. **Revocation**. I understand that I may revoke this Authorization, in writing, at any time, by sending a signed, written notification of revocation to the Health Care Provider by writing to **Privacy Officer, ICMS, 15 Medical Center Loop, Vinalhaven, ME 04863**. I understand that, if I revoke this Authorization, it will not affect actions or disclosures already taken by the Health Care Provider in reliance on the Authorization prior to the Health Care Provider's receipt of the revocation. I understand that the revocation will not be effective if the Authorization was obtained as a condition of obtaining insurance coverage, to the extent that other law provides the insurer with the right to contest a claim under the policy or the policy itself. I also understand that revocation of this Authorization may be the basis for denial of health benefits or other insurance coverage or benefits. I understand that the exceptions to the right to revoke and a description of how to revoke this Authorization are included in the Health Care Provider's Notice of Privacy Practices.
3. **Right to Refuse Authorization.** I understand that I may refuse to authorize the use and/or disclosure of all or part of my health information, but such refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance, or other adverse consequences.
4. **Authorization Not Required.** I understand that the Health Care Provider will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure, <u>except:</u> (a) if my treatment is related to research, then an authorization may be required; or (b) if the purpose of the health care is solely to create PHI to provide the PHI to a third-party, then an authorization may be required.
5. **Expiration of Authorization.** I understand that this Authorization shall be in effect until the date OR event set forth below, whichever occurs earlier, at which time this Authorization shall expire. Except as may otherwise be permitted under Maine law, this Authorization is NOT valid for more than thirty (30) months from the date signed. Complete ONE of the following: **Date: (*Month/Date/Year*) __/____/_____; OR Event: _____**
6. **Copy of Authorization.** I understand that I have a right to receive a copy of this Authorization.
7. **Voluntary. I understand that I am voluntarily executing this Authorization**

Patient Signature:_____

Printed Name:_____ **Date:**_____

If not signed by the Patient/Individual, please provide the following information:

Personal Representative's Signature:_____

Printed Name:_____ **Date:**_____

Relationship to Patient:_____

Basis of authority to act as Personal Representative (such as Durable Power of Attorney, Appointment by Court, Parent of Minor, Guardian, Court Order):_____