New England
Naturopathic Health
Corrie Marinaro, Naturopathic Doctor
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157 Silver Street
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www.naturopathicme.com
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Authorization to Release Health Care Information

Name of Patient (please print): _____

Patient Date of Birth: _____ Phone Number: _____

I give permission for New England Naturopathic Health

☐ To give information to **OR** ☐ To receive information from the person/place listed below:

Physician's Name and Practice Name:_____

_____

Street City/Town State Zip Code

_____

Phone Number Fax Number

I would like the following information to be released:

☐ History & Physical ☐ Test Results ☐ Psychosocial Evaluation
☐ Discharge Summary ☐ Emergency Room Records ☐ Psychiatric/Psychological Evaluation
☐ Operative Report ☐ Office Notes ☐ Other: _____
☐ Assessment/Care Plan/Notes

These are the dates of treatment I would like released: _____

I authorize the release of the above information for the purpose of:

☐ Coordinating/managing my care
☐ Transferring care to another provider
☐ My own records/use
☐ Other: _____

I authorize information to be released by means of: (pick only one) **No discs please.**

☐ Paper copy ☐ Fax (send to us via FAX# 207-352-5217)

By signing this form, I acknowledge that New England Naturopathic Health has privacy and security protections for my information. I understand that there are risks that New England Naturopathic Health cannot control. It is possible that my information could be read by a third party. I accept those risks by signing this form and allowing delivery of my records by mail or Fax.

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I understand that:

■ Signing this authorization is not required for receiving treatment, payment, enrollment and eligibility for benefits.

■ I can refuse to disclose some or all of the information in my treatment records. If I do so, it could result in an improper diagnosis or treatment, denial of coverage, a claim for health benefits or other insurance or adverse consequences.

■ I can revoke all or part of this authorization at any time by delivering a written, dated and signed notification. Or I can make an oral statement revoking this authorization to the facility listed above except to the extent that New England Naturopathic Health has already acted in reliance on it. I am entitled to a copy of this authorization, upon request.

■ Information disclosed through this authorization may be shared again by the recipient and therefore no longer protected by the privacy laws.

■ I can cross out any provision on this form with which I disagree.

■ Records are kept according to state regulatory guidelines. Some older records may not be available for release because they are beyond these retention periods.

■ Maine law allows reasonable fees to be collected for copies of medical records which may not exceed processing costs.

State and federal laws require your specific consent to disclose any of the following types of information
(check the boxes next to the disclosures you wish this authorization to include)

☐ I authorize the disclosure of information about substance use disorder program treatment. If you authorize the disclosure of such information, the recipient may not redisclose the information unless you give your written consent or such re-disclosure is otherwise permitted by 42 C.F.R. Part 2.

☐ I authorize the disclosure of information pertaining to mental health treatment. Initial here if you wish to review this information before its disclosure _____

☐ I authorize the disclosure of information pertaining to HIV(Human Immunodeficiency Virus) treatment or testing. If you check this box, please know that persons who have disclosed HIV information have encountered discrimination in the areas of employment, housing, education, life insurance, health insurance and social and family relationships.

This authorization is effective until: _____ (date not to exceed one year.) Records created after the signature date may require a new authorization form.

_____

Signature of Patient Date

_____

Signature of Authorized Representative Relationship