HIM: NO ACTION NEEDED UNLESS INSTRUCTED OTHERWISE

INTERMED
Care without compromise.

**INTERMED BEHAVIORAL HEALTH**

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

- By completing this authorization form I agree to allow sharing of my medical information either **verbally** or through **release of records** between the providers listed below.
- I understand that the purpose of this authorization is to allow sharing of my health information to aid in the coordination of my care.
- I understand that I am not required to complete this form in order to receive care. I understand that my refusal to complete the form may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

**From/To:**
**InterMed Behavioral Health**

**To/From:**
**Provider #1**:_____
Practice Name:_____
Phone/Fax: _____

**Provider #2**:_____
Practice Name:_____
Phone/Fax: _____

**Please indicate below what information may be shared.**

☐All of my medical information ☐Only the following information: _____

_____

I understand that some medical information has special protections and requires my specific consent. I understand that authorizing the release of the information below does not confirm that I have had treatment or that the information exists.

**Please check your preference below:**

☐I Do ☐I Do Not authorize the release of information related to **mental health treatment.**

☐I Do ☐I Do Not authorize the disclosure of information from a **substance use disorder** treatment facility or program.

☐I Do ☐I Do Not authorize the release of information related to **HIV infection status or treatment**

**I understand that:**

- This authorization is valid for **24 months** from the date I sign it.
- I have the right to revoke this authorization in writing by sending a written request to InterMed's HIM department. I may call the number below for instructions on how to submit this request.
- Revocation will not cover information released prior to that date, but will prevent further release of information.
- Information released may be further released by the receiving party and that, if this occurs, InterMed cannot guarantee the protection of this information once disclosed.
- I have the right to request a copy of this authorization.

**Patient/Guardian Signature**_____ **Date**_____

Printed Name (if not patient) _____

Relationship: ☐Parent ☐Legal Guardian ☐Other legally authorized representative: _____

**100 Gannett Drive, Suite C, South Portland, ME 04106** **Telephone: 207-523-3745 Fax: 207-523-8581**