INTERMED
Care without compromise.

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

If this form is not filled out in its entirety it will result in a delay in processing.

Patient Name:_____ Previous Name:_____ DOB:_____
Address:_____ Telephone Number: _____

I understand that health care information is confidential and will not be disclosed without my authorization, unless otherwise permitted by law. I understand that InterMed cannot condition treatment or payment on whether I sign this form. If I do not sign this form, however, I understand that my refusal could result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

I hereby authorize InterMed, P.A.: *(Please check)* ☐ **Disclose the information described below to:**
☐ **Obtain the information described below from:**

InterMed, P.A. _____
(Name of person/entity/type of entity)

100 Gannett Drive, Suite C _____
(Address of recipient)

South Portland, ME 04106 _____
(City/State/Zip Code of recipient)

(207) 523-3963 opt. 2 (phone), (207) 523-8581 (Fax) _____
(Phone and Fax Numbers of recipient)

Please disclose: (Check appropriate box or boxes):

☐ Lab results ☐ Radiology reports ☐ Other (specify):
☐ Physical Exams ☐ Radiology films _____
☐ Office Visits ☐ Last two (2) years of health record
If more than two (2) years of records are required, please specify time frame: _____

I understand that my specific consent is necessary to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status. I understand that authorizing the release of such information does not confirm the existence of such history or treatment. **By checking the boxes below, I do authorize that specific health information to be released:** ☐ Mental Health Treatment ☐ Alcohol and/or Drug Abuse Treatment ☐ AIDS/HIV

The purpose of the disclosure is:

☐ Transfer of care (leaving InterMed):
Please indicate the reason for transfer below (optional)
- Reason for transfer: _____
- Insurance changes (please list new insurance): _____

☐ Coordination of Care (NOT transferring) ☐ Disability/FMLA ☐ Insurance Application
☐ Legal Matter(s) ☐ At my Request ☐ Workers Compensation

This authorization expires 24 months from the date I sign it. I have the right to revoke this authorization in writing at any time. This will not apply to information disclosed before I provide my revocation but will prevent further disclosures. I understand that once this information is disclosed, it may no longer be subject to Federal privacy rules and might be further disclosed by the recipient. I understand that I have a right to request a copy of the authorization. My signature below indicates that I have read and understand this authorization.

X_____ _____
Patient or Representative Signature (*if not patient*) **Signature Date**

☐ Parent ☐ Legal Guardian ☐ Other Legally Authorized Representative: _____