INTERMED
Care without compromise.

AUTHORIZATION TO RELEASE 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 released without my authorization unless permitted by law. I understand that I have the right to refuse authorization to disclose all or some health care information, but refusal may result in improper diagnosis or treatment, denial of insurance coverage, or other adverse consequences.

Please tell us where the records are coming from:

Physician/Individual Name: _____
Address: _____
City/State/Zip Code: _____
Phone Number: _____
Fax Number: _____

Please tell us where the records are going to:

Physician/Individual Name: _____
Address: _____
City/State/Zip Code: _____
Phone Number: _____
Fax Number: _____

By law, providers are required to release the minimum amount of information necessary to carry out the purpose of a release. Please indicate below exactly which records you would like to be released.

☐ Lab results ☐ Physical exams ☐ Office visits ☐ Radiology reports ☐ Radiology Films
☐ Last 5 years of health record ☐ Other (please specify): _____

The information and material above may only be used for the following purpose(s) please check below:

☐ Transfer of Care: Please indicate the reason for transfer below

- Reason for Transfer: _____
- Insurance changes please indicate new insurance: _____
- Dissatisfaction: _____

☐ Coordination of Care (**NOT** Transferring) ☐ Disability/FMLA ☐ Insurance Application
☐ Legal Matter(s) ☐ Self ☐ Workers Compensation Claim

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 authorize that specific health information to be released:

☐ AIDS/HIV ☐ Alcohol and/or Drug Abuse Treatment ☐ Mental Health Treatment

This authorization expires (12) months from the date hereof. I have the right to revoke this authorization in writing at any time. Revocation will not cover information/material released prior to that date, but will prevent further release of information. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.
My signature below indicates that I have read this release form and have had all of my questions answered, if any.

- I understand what this form authorizes.
- I consent to the release of information as recorded on this form.
- I authorize the party (ies) listed in section 1 of this form to make subsequent disclosures to the same recipient pursuant to this authorization.
- I understand that information released might be further released by the receiving party and that if this occurs, InterMed cannot guarantee the protection of this information once disclosed.
- I understand that I have a right to request a copy of the authorization.

X_____ _____
Patient or Representative Signature **Date**

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

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