Kennebec Eye Care, P.A.
Authorization To Release Health Care Information

Where records are now:
(Dr.)_____
(Practice)_____
(Street)_____
(City/Town)_____
(State)_____(Zip)_____

To receive records:
(Dr.)_____
(Practice)_____
(Street)_____
(City/Town)_____
(State)_____(Zip)_____

I, _____give_____,its authorized employees and
(Patient name/representative) (Doctor/facility)
agents permission to disclose the health care information described below relating to_____

Purpose of request:
_____To provide ongoing treatment and care.
_____To coordinate treatment efforts with other physicians, family members, and others.
_____Other:_____.

Information to release:
1._____All information including history, dates, course and outcome of treatment.
NOTE: I understand that my record may contain information related to drug and/or alcohol use, psychiatric treatment, sexually transmitted disease, HIV treatment or other sensitive information.
2. Release only the following information:
_____Physician Office Records _____Hospital Records (in/outpatient)
_____Other Treatment records _____Test Results
_____Statements I have added

Information I Refuse to release:_____

NOTE: I can refuse to disclose some of my records. Partial or incomplete records will be labeled as such to inform the provider receiving them of their status.

I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wishes to ***Kennebec Eye Care, P.A.***

A decision to withdraw my consent to release records or refusal to disclose some of my records, however, may result in an improper diagnosis or treatment, denial of health benefits or insurance coverage or benefits or other adverse consequences.

PATIENT INITIALS_____

My consent to release my records is effective until_____. (Date not to exceed 30 months from consent).
I do_____ Ido not_____authorize re-release of the information. **(A copy of this form is available to signer upon request.)**

_____ _____ _____
(Signature of patient or legal rep) (Relationship to patient) (Date)

Patient Name:_____ Date of Birth_____ SSAN:_____

Street_____ City/Town_____Zip_____