INTERMED
Care without compromise.

AUTHORIZATION TO DISCLOSE HEALTH CARE INFORMATION

Note: If this form is not completed in its entirety, it will result in a delay in processing.

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

Section 1: I hereby authorize InterMed, P.A.: (Please select one)

☐ **Verbal communication only to/from:**
☐ **Disclose the information described below to:**
☐ **Obtain the information described below from:**

InterMed, P.A.
100 Gannett Drive, Suite C.
South Portland, ME 04106
Phone: (207) 523-3963 opt 2., Fax: (207) 523-8581

Name/Facility:
Address:
City, State, Zip Code:
Phone Number:
Fax Number or Email:

Section 2: Purpose of Request: (Select at least one)

☐ Transfer of care (leaving or joining InterMed)
- Please indicate the reason for transfer (optional): _____

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

Section 3: Please authorize the following information: (Select all that apply)

☐ Last Two (2) Years of Medical Records
☐ Physical Exams
☐ Office Visit Notes
☐ Immunization Records
☐ Lab and Pathology Results and Reports
☐ Radiology Reports
☐ Radiology Films
☐ Other Specific Records: _____
☐ If more than two (2 years) of records are required, please specify the time frame: _____

Section 4: Sensitive information to be released:

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 of treatment. **By checking the boxes below, I DO NOT authorize that specific health information to be released:**

☐ Information derived from services by a mental health professional
☐ Alcohol and/or Drug Abuse Treatment
☐ AIDS/HIV
I do not wish to review mental health, substance abuse or HIV records prior to disclosure ☐

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.

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.

Signature:_____ **Date**:_____

Relationship to patient (if not patient): ☐ Parent ☐ Legal Guardian ☐ Other Legally Authorized Representative