Nasson Health Care
a division of York County Community Action Corporation

MAILING ADDRESS
15 Oak Street | Springvale, ME 04083

LOCATIONS
15 Oak Street | Springvale, ME 04083
357 Elm Street | Biddeford, ME 04005

P: (207) 490-6900 | F: (207) 459-2822
NassonHealthCare.org

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION FROM NASSON HEALTH CARE

Client Name: _____ **Date of Birth**:_____

I authorize/request Nasson Health Care to release information to:

_____

Organization Name **Address** **Telephone Number** **Fax Number**

Nasson Health Care is authorized to disclose and discuss the following:

□ Discharge Summary	□ EKG	□ Radiology Reports	□ Last Mammogram Report
□ History & Physical	□ Operative Notes	□ Medication Record	□ Last Dental X-Rays –within 1 year
□ Immunizations	□ Lab Reports	□ Last Pap Report	□ Office Notes – within 3 year

□ Other: _____

I DO _____ / DO NOT _____ authorize the release of any information, which refers to the diagnosis or treatment of **ALCOHOL OR DRUG ABUSE** under this authorization.

I DO _____ / DO NOT _____ authorize the release of any information, which refers to the diagnosis of treatment of **MENTAL HEALTH** under this authorization**.**

I DO _____ / DO NOT _____ authorize the release of any information, which refers to the testing, diagnosis or treatment of **HIV/AIDS**.

Purpose of the above release (*Place a check mark by each appropriate option)*

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

□ Verification of Services □ Ongoing Service Coordination □ Treatment/Service Planning

□ Transfer my healthcare □ Legal Matter □ Other *(specify):*_____

My signature below indicates that I have read this release form and have had all of my questions answered, if any. I understand:

- I understand that this form authorizes the release of information as indicated on this form.
- I have the right to revoke this authorization verbally by speaking with designated NHC staff or by submitting a Revocation 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 insurance coverage or benefits.
- I authorize the party(s) I have authorized to make subsequent disclosures to the same recipient pursuant to this authorization.
- I understand that information released by Nasson Health Care might be further released by the receiving party noted above, and that if this occurs; Nasson Health Care cannot guarantee the protection of this information once disclosed.
- I understand that the recipient of such information may not further release this information without my specific consent or unless permitted by law. I understand that health care information is confidential and will not be released without my authorization unless permitted or mandated 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, or denial of insurance coverage.
- I understand that my records pertaining to alcohol and substance use are protected under Federal Regulation, 42 CFR Part 2, which prohibits these records from being disclosed or re-disclosed without written consent, unless otherwise provided for in the regulations. **Re-disclosure** of my records by those reviewing the above authorized information may not be accomplished without my written consent.
- I understand that I have the right to review indicated material before it is released.

This authorization expires: □ 6 months from today, or □ On ___/__/____ Specify date

Client Signature_____ **Date**_____

Representative*_____ Date_____

***Relationship to client ____ Parent ____ Legal Guardian _____ Other Legal Representative (specify):_____**