IMSM Medical Record Release

Internal Medicine of Southern Maine

**Patient Information**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_

**Release Information from:**(please check)

\_\_\_\_SMHC/MaineHealth \_\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release Information to:**

Name/Facility-**Internal Medicine of Southern Maine, LLC**

**2 Independence Drive, Suite B Kennebunk, ME 04043**

Phone Number-**207-467-3200** Fax number-**207-910-6530**

**Information To Be Released:**

Release all info unless otherwise specified. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sensitive Information To Be Released**(please circle)

I understand that the information to be released may contain sensitive information and that unless I

specify below, I hereby authorize release of the following types of information.

**I DO** or I **DO NOT** authorize disclosure of any information related to diagnosis and/or treatment of Mental Health.

**I DO** or **I DO NOT** authorize disclosure of any information relating to Alcohol, Substance and/or

Drug Use.

**I DO** authorize disclosure of information which refers to HIV Results, Infection Status and/or

Treatment.

**Disclosure format**

\_X\_Epic view only access \_\_Paper \_\_CD \_\_Fax

**Purpose of Release**(please circle) Transfer of Care, Personal /Legal Purposes, Worker’s Comp,

Disability/Insurance Application/Claim, Continuing Care, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of person signing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Authorized Representative (ex.Parent, Guardian, or Power of Attorney)\_\_\_\_\_\_\_\_\_\_\_\_\_