



**CHEST MEDICINE ASSOCIATES**

*Pulmonary, Critical Care and Sleep Medicine*

335 Brighton Avenue, Portland, ME 04102 P: (207) 828-1122 F: (207) 828-0188

**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**

I, \_\_\_\_\_ (print name), hereby authorize Chest Medicine Associates (CMA), its authorized employees or agents, to disclose and discuss records containing the following health care information to (name and address): Mid Coast Medical Group (MCMG), 121 Medical Center Drive, Brunswick, Maine 04011

**Please Specify Applicable Dates, Illnesses, or Other Information, if necessary**

Inpatient \_\_\_\_\_  \_\_\_\_\_ f. Other Practitioner Record \_\_\_\_\_  \_\_\_\_\_  
Outpatient \_\_\_\_\_  \_\_\_\_\_ g. Records from Other Facilities \_\_\_\_\_  \_\_\_\_\_  
Emergency Room \_\_\_\_\_  \_\_\_\_\_ h. Statements I Added to Records/Any Responses \_\_\_\_\_  
Clinic \_\_\_\_\_  \_\_\_\_\_ i. Specific Illness/Injury \_\_\_\_\_  \_\_\_\_\_  
Physician Office Records \_\_\_\_\_  \_\_\_\_\_ j. Test Results \_\_\_\_\_  \_\_\_\_\_

Other information to be disclosed (specify): \_\_\_\_\_

Information that I refuse to release (specify): \_\_\_\_\_

**The purpose of this release is to transfer my pulmonary care from CMA to MCMG.**

I understand that my medical record contains information relating to my diagnosis and treatment and authorize the release of all the information listed above, except those items I have crossed out or specified. I understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Partial or incomplete records will be labeled as such.

This Authorization expires \_\_\_\_\_ days/months from the date hereof (not to exceed thirty (30) months) and subsequent disclosures by Chest Medicine Associates are permitted until expiration. However, I understand that I can revoke this Authorization at any time prior to the above date by notifying Chest Medicine Associates of the revocation. Such revocation must be in writing, signed, and dated and shall be effective when received, subject to the rights of any person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis for denial of health benefits or other insurance coverage or benefits.

If I have been diagnosed or treated for any of the following, I understand Chest Medicine Associates needs my specific consent to disclose related information I may cross out any of the following which do not apply.

1. I (**DO/DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse. Such information may not be re-disclosed by the recipient without my specific written consent.
2. I (**DO/DO NOT**) authorize disclosure of information which refers to treatment or diagnosis of psychiatric illness. I (**DO/DO NOT**) wish to review such information prior to its release. Review must be supervised.

I understand that I am entitled to a copy of this authorization form.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Signed \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Signature

Please Mail or Fax Completed and Signed document to:  
335 Brighton Avenue, Portland, ME 04102 Fax: (207) 828-0188