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)_____

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity of the same record set requested pursuant to this authorization, unless I notify the office in writing that no future disclosures should be made.