Bangor
OB/GYN

We love to care for you, and it shows.

Uncomplicated Pregnancy
High Risk Pregnancy
Gynecology
Pelvic Surgery
Hormonal Replacement
Breast Conditions

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I, _____ give _____, its authorized employees and agents permission to disclose to and discuss with _____ the health care information described below relating to_____ Information to be released:

a. Obstetrical Reports
b. Hospital Records
c. Office Notes
d. Pap Smears
e. CT scans
f. Pathology Reports
g. Ultrasounds
h. Laboratory Results
i. MMG Reports
j. Consult Reports

State and Federal Laws require my specific consent to disclose information pertaining to **HIV testing or treatment, mental health treatment** and/or **substance abuse treatment** information. I understand that I may request to review any information in my medical record, and may refuse to disclose some or all of my records. However, such refusal may result in improper diagnosis or treatment, denial of insurance benefits, or other adverse effects. I understand that my records may contain information pertaining to **HIV testing or treatment, mental health treatment,** and/or **substance abuse treatment,** and I agree to the release of this information by signing below.

✓ Signed: _____ Date: ✓ _____

I understand that:

- I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wishes to Bangor OB/GYN. A decision to withdraw my consent to release records, however, may be the basis for a denial of health benefits or insurance coverage benefits.
- I can refuse to disclose some or all of my records, but if I do so, it could 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 to inform the provider receiving them of their status.
- I can have a copy of this form upon request.
- I can cross out any provision on this form with which I disagree.

My consent to release these records if effective for 12 months from date this release is signed.
I authorize Bangor OB/GYN to make future disclosures regarding these records to the same individuals or entities during the 12 month time periods.

A parent or guardian is generally required to sign for a patient under the age of 18. If an adult is unable to make or communicate medical decisions, then the following may sign in the priority given: agent under health care power of attorney, guardian, spouse, and next-of-kin. Indicate capacity of representative.

✓ Patient's D.O.B_____ Patient's S.S._____

✓ Signed : _____ Date: _____
(Patient)

Signed: _____ Date: _____
(Patient Representative*)

Witness: _____ Date: _____

Clerical	Copying	Delivery
No Fee	No Fee	Cost of Postage
No Fee	No Fee	Cost of Postage

Billed directly to Insurance / Attorney

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